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1st Session

HOUSE OF REPRESENTATIVES

REPT. 96-404
PART 2

HOSPITAL COST CONTAINMENT ACT OF 1979

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

together with

MINORITY AND SEPARATE VIEWS

[To accompany H.R. 2626]

[Including cost estimate and comparison of the Congressional Budget Office]

OCTOBER 9, 1979.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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HOSPITAL COST CONTAINMENT ACT OF 1979

OCTOBER 9, 1979.—Ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

[To accompany H.R. 2626 which on March 6, 1979, was jointly referred to the Committee on Interstate and Foreign Commerce and the Committee on Ways and Means for a period ending not later than October 9, 1979]
[Including Cost Estimate and Comparison of the Congressional Budget Office]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 2626) to establish voluntary limits on the annual increases in total hospital expenses, and to provide for mandatory limits on the annual increases in hospital inpatient revenues to the extent that the voluntary limits are not effective, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment strikes out all after the enacting clause of the bill and inserts a new text which appears in boldface roman type in the reported bill:

SHORT TITLE; TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Hospital Cost Containment Act of 1979".

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TITLE I—VOLUNTARY HOSPITAL COST CONTAINMENT PROGRAM

PART A—ESTABLISHMENT OF VOLUNTARY PERCENTAGE LIMITS

NATIONAL VOLUNTARY PERCENTAGE LIMIT

SEC. 101. (a) The Secretary, before April of each year (beginning with 1980 and ending with last year of the national voluntary period, as determined under section 115(a), shall promulgate a national voluntary percentage limit for the preceding year, which shall be equal to the sum of the following four amounts as computed by the Secretary):

(1) WAGES OF NONSUPERVISORY EMPLOYEES.—The percent increase in the national hospital wage marketbasket (as defined in section 323(2)) for that preceding year.

(2) NONWAGE HOSPITAL MARKETBASKET.—The greater of—

(A) the percent increase in the national hospital nonwage marketbasket (as defined in section 323(1)) for that preceding year, or

(B) (i) for 1979, 6.5 percent, or

(ii) for any other year, the percent increase in the national hospital nonwage marketbasket for that preceding year as estimated and announced under subsection (b)(1).

(3) POPULATION INCREASE FACTOR.—The percent increase in the national population (as defined in section 324(2)) for that preceding year.

(4) NET SERVICE INTENSITY ALLOWANCE.—One percent.

Notwithstanding the preceding provisions of this subsection, the national voluntary percentage limit for 1979 shall not be less than 11.6 percent.

(b) The Secretary, before the first calendar quarter beginning after the date of the enactment of this Act and before each succeeding calendar quarter of a year before 1985, shall estimate and announce—

(1) the percent increase in the national nonwage marketbasket for the twelve-month period beginning with that calendar quarter, and

(2) the sum of the average fractions of expenses of hospitals in the United States (described in section 323(1)(B)) attributable to classes of goods and services used in the computation of the percent increase (described in paragraph (1)) for that twelve-month period.

INDIVIDUAL HOSPITAL VOLUNTARY PERCENTAGE LIMITS

Sec. 102. (a)(1) The Secretary shall compute an individual hospital voluntary percentage limit under this section for each accounting year of a hospital ending during the period beginning January 1, 1979 and ending December 30, 1984.

(2) The Secretary shall compute these limits for a hospital's accounting period that ended—

(A) in 1979, before July 1, 1980, or

(B) after 1979, not later than six months after the end of the accounting period.

(b)(1) For a hospital's accounting period that ended on December 31, 1979, such limit shall be equal to the sum of the following four amounts:

(A) Wages of nonsupervisory employees.—The percent increase in the wage marketbasket (as defined in section 323(4)) of the hospital for the accounting period.

(B) Nonwage *H*ospital marketbasket.—The greater of (i) the percent

(1) for the accounting period, multiplied by the fraction of the accounting

(B) Nonwage hospital marketbasket.—The greater of (i) the percent increase in the nonwage marketbasket (as defined in section 323(3)) of the hospital for the accounting period, or (ii) 6.5 percent.

(C) Population change factor.—The percent change in area population as defined in section 324(1)) for the accounting period of the hospital.

(D) Net service intensity allowance.—One percent.

(2) For a hospitals' accounting period that ended in 1979 before December 31, such limit shall be equal to the sum of the following two amounts:

(A) 1978 Factor.—The percentage increase in the hospital's expenses in its accounting period that ended in 1978 over its expenses in its preceding accounting period, multiplied by the fraction of the accounting period ending in 1979 that occurred in 1978.

(B) 1979 Factor.—The sum of the four amounts described in paragraph

(1) Wages of nonsupervisory employees.—The percent increase in the period that occurred in 1979.

(c) For a hospital's accounting period that ended after 1979, such limit shall be equal to the sum of the following four amounts:

(1) W ages of nonsupervisory employees.—The percent increase in the wage marketbasket (as defined in section 323(4)) of the hospital for the accounting period.

(2) Nonwage hospital marketbasket.—The greater of—

(A) the percent increase in the nonwage marketbasket (as defined in section 323(3)) of the hospital for the accounting period, or

(B)(i) for an accounting period that began before the beginning of the first calendar quarter beginning after the date of the enactment of this act, 6.5 percent, or

(ii) for any other accounting period, the percent increase in the national hospital nonwage marketbasket as estimated and announced under section 101(b)(1) for the twelve-month period beginning with the calendar quarter in which the accounting period began, multiplied by the hospital's adjustment factor (as defined in section 323(5)) for the accounting period.

(3) Population change factor.—The percent change in area population (as defined in section 324(1)) for the accounting period of the hospital.

(4) Net service intensity allowance.—One percent.

(d)(1) A hospital may elect, in such manner and in accordance with such procedures as the Secretary shall provide, to exclude from the computation of its individual hospital expenses for purposes of the determination of its individual hospital voluntary percentage limit under this section and its in-

dividual hospital performance under section 114 for all accounting periods of the hospital (beginning with the first accounting period for which the election is made)—

(A) expenses attributable to charity care (as defined in paragraph (2)(A)),

(B) expenses attributable to bad debts (as defined in paragraph (2)(B)),

(C) capital-related expenses (including depreciation and interest) related to capital expenditures which—

(i) significantly increase bed capacity or significantly expand services, capacity, or both, and

(ii) have been approved by the State health planning and development agency for the hospital,

to the extent these expenses have not been included in the hospital's expenses for the previous accounting period, or

(D) patient care and teaching expenses related to a major expansion of a medical teaching program to the extent such expenses are not included in the previous accounting period,

or any combination of such types of expenses for the accounting period.

(2) For purposes of paragraph (1)—

(A) the term "expenses attributable to charity care" means, with respect to a hospital's accounting period, expenses relating to care, provided to patients by the hospital, for which reductions in (or elimination of) charges are made, as established by the hospital to the satisfaction of the Secretary, because of the indigence or medical indigence of the patients, and

(B) the term "expenses attributable to bad debts" means, with respect to a hospital's accounting period, expenses relating to care, provided to patients by the hospital, for which there are charges, to the extent to which the hospital establishes to the satisfaction of the Secretary, that (i) it has made reasonable efforts to collect such charges, (ii) any uncollected amounts are in fact uncollectible, and (iii) there is not substantial likelihood of their future collection.

Part B—Review of Performance During Voluntary Period National Hospital Performance

Sec. 111. (a) The Secretary, before July 1, 1980, and before July 1 of any succeeding year that follows a year during the national voluntary period (as determined under section 115(a)), shall determine whether the increase in hospital expenses in the United States in the preceding year over those expenses in the second preceding year exceeded the national voluntary limit for the preceding year. He shall make that determination as follows:

(1)(A) He shall assign to each hospital's accounting period that ended on December 31 of that preceding year the national voluntary percentage limit (computed under section 101) for that preceding year.

(B) If the preceding year was 1979, he shall assign to each hospital's accounting period ending in 1979 before December 31 the sum of—

(i) 12.8 percent multiplied by the fraction of the accounting period that occurred in 1978, and

(ii) the national voluntary percentage limit for 1979 multiplied by the fraction of the accounting period that occurred in 1979.

(C) If the preceding year was 1980 or later, he shall assign to each hospital's accounting period ending before December 31 in that preceding year the sum of—

(i) the national voluntary percentage limit for the second preceding year multiplied by the fraction of the accounting period that occurred in that second preceding year, and

(ii) the national voluntary percentage limit for that preceding year multiplied by the fraction of the accounting period that occurred in that preceding year.

(2) He shall compute the dollar amount by which each hospital's expenses in its accounting period ending in that preceding year exceeded (or was less than) its expenses in its preceding accounting period increased by the percentage limit assigned under paragraph (1) to the hospital's accounting period ending in that preceding year.

(3)(A) He shall compute the sum of the dollar amounts computed under paragraph (2).

(B)(i) For 1979, if the sum is greater than zero, he shall announce that the increase in hospital expenses in the United States for the preceding year exceeded the national voluntary limit for that year.

(ii) For 1979, if the sum is equal to or less than zero, he shall announce that the increase did not exceed the national voluntary limit for the preceding year and he shall credit, to a national carryforward account, an amount equal to one-half of the dollar amount of such savings.

(iii) Immediately before making a determination under this subsection for a year after 1979, the amount of any balance in the national carryforward account shall be increased by a percentage equal to the national voluntary percentage limit for the year.

(C)(i) For a year after 1979, if the sum is greater than zero, he shall apply, against such sum and to the extent of such sum, any balance in the national carryforward account (described in subparagraph (B)(ii)). If, after applying some or all of such balance, the sum is equal to zero, the Secretary shall announce that the increase in hospital expenses in the United States did not exceed the national voluntary limit for the preceding year and shall debit, against the national carryforward account, the amount of the account applied. If, after applying all of such balance, the sum is still greater than zero, he shall announce that the increase in hospital expenses in the United States for the preceding year exceeded the national voluntary limit for that year and shall reduce to zero the balance in the national carryforward account.

(ii) For a year after 1979, if the sum is equal to or less than zero, he shall announce that the increase did not exceed the national voluntary limit for the preceding year and he shall credit, to the national carryforward account, an amount equal to one-half of the dollar amount of such savings for such year.

(b)(1) The Secretary shall report to each House of Congress on his announcement under subsection (a) and include in the report details as to the basis for the announcement.

(2) Such report shall be delivered to each House of the Congress on the same date and to each House of the Congress while it is in session. Such report made to the House of Representatives shall be referred to the Committee on Ways and Means and to the Committee on Interstate and Foreign Commerce, and such report made to the Senate shall be referred to the Committee on Finance and to the Committee on Labor and Human Resources.

CONGRESSIONAL REVIEW OF NATIONAL HOSPITAL PERFORMANCE

SEC. 112. (a)(1) A report submitted to Congress under section 111(b) shall be considered disapproved for purposes of section 115(a) if—

(A) before the end of the period of 45 calendar days of continuous session after the date the report is submitted to Congress, one House of the Congress adopts a resolution disapproving such report, and

(B) before the end of such 45 day period, or, if later, the fifteenth day of continuous session after the date one House of Congress adopts (during such 45-day period) a resolution disapproving such report, the other House has not adopted a resolution approving such report.

(2) For the purpose of paragraph (1)—

(A) continuity of session is broken only by an adjournment of Congress sine die, and

(B) the days on which either House is not in session because of an adjournment of more than three days to a day certain are excluded in the computation of days of continuous session.

(b)(1) This subsection is enacted by Congress—

(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of resolutions described in paragraph (2) of this subsection, and it supersedes other rules only to the extent that it is inconsistent therewith; and

(B) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rules of the House.

(2) For purposes of this subsection, the term "resolution" means only a resolution of either House of Congress the matter after the resolving clause of which is either—

(A) "That the disapproves the report of the Secretary of Health, Education, and Welfare, made under section 111(b) of the Hospital Cost Containment Act of 1979, relating to the Secretary's announcement that the increase in hospital expenses in the United States for has exceeded the national voluntary limit for that year.", or

(B) "That the approves the report of the Secretary of Health, Education, and Welfare, made under section 111(b) of the Hospital Cost Containment Act of 1979, relating to the Secretary's announcement that the increase in hospital expenses in the United States for has exceeded the national voluntary limit for that year.",

the first blank space therein being filled with the name of the resolving House and the other blank being filled in with the number of the year for which the announcement was made.

(3) In the case of a resolution introduced in the House of Representatives, the Speaker of the House of Representatives shall immediately refer the resolution jointly to the Committee on Ways and Means and to the Committee on Interstate and Foreign Commerce. In the case of a resolution introduced in the Senate, the President of the Senate shall immediately refer the resolution jointly to the Committee on Finance and to the Committee on Labor and Human Resources.

(4)(A) If the committees in a House of Congress to which a resolution has been referred have not reported it at the end of 30 calendar days after its referral, it shall be in order to move to discharge the committees from further consideration of such resolution.

(B) A motion to discharge shall be highly privileged (except that it may not be made after the committees have reported a resolution with respect to the same report), and debate thereon shall be limited to not more than one hour, to be divided equally between those favoring and those opposing the resolution. An amendment to the motion shall not be in order, and it shall not be in order to move to reconsider the vote by which the motion was agreed to or disagreed to.

(C) If the motion to discharge is agreed to or disagreed to, the motion may not be renewed, nor may another motion to discharge the committees be made with respect to any other resolution with respect to the same report.

(5)(A) When the committees have reported, or have been discharged from further consideration of, a resolution, it shall be at any time thereafter in order (even through a previous motion to the same effect has been disagreed to) to move to proceed to the consideration of the resolution. The motion may be made only by an individual favoring the resolution, shall be highly privileged, and shall not be debatable. An amendment to the motion shall not be in order, and it shall not be in order to move to reconsider the vote by which the motion was agreed to or disagreed to.

(B) Debate on the resolution referred to in subparagraph (A) shall be limited to not more than five hours, which shall be divided equally between those favoring and those opposing such resolution. A motion further to limit debate shall not be debatable. The only amendment that shall be in order with respect to a resolution described—

(i) in paragraph (2)(A) is an amendment to strike all after the resolving clause and to insert in lieu thereof the matter described in paragraph (2)(B), or

(ii) in paragraph (2)(B) is an amendment to strike all after the resolving clause and to insert in lieu thereof the matter described in paragraph (2)(A),

and no amendment (or substitute) to such an amendment shall be in order. A motion to recommit the resolution shall not be in order, and it shall not be in order to move to reconsider the vote by which such resolution (or an amendment to the resolution) was agreed to or disagreed to.

(6)(A) Motions to postpone, made with respect to the discharge from committees, or the consideration of a resolution and motions to proceed to the consideration of other business, shall be decided without debate.

(B) Appeals from the decision of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to a resolution shall be decided without debate.

(c)(1) Any interested party may institute such actions in the appropriate district court of the United States, including actions for declaratory judgment, as may be appropriate to construe the constitutionality of this section and sec-

tion 115(a)(2). The district court immediately shall certify all questions of the constitutionality of such provisions to the United States court of appeals for the circuit involved, which shall hear the matter sitting en banc.

(2) Notwithstanding any other provision of law, any decision on a matter certified under paragraph (1) shall be reviewable by appeal directly to the Supreme Court of the United States. Such appeal shall be brought not later than 20 days after the date of the decision of the court of appeals.

(3) It shall be the duty of the court of appeals and of the Supreme Court of the United States to advance on the docket and to expedite to the greatest possible extent the disposition of any matter certified under paragraph (1).

STATE HOSPITAL PERFORMANCE

SEC. 113. The Secretary, before July 1, 1980, and before July 1 of any succeeding year before 1985, shall determine whether the increase in hospital expenses in the State in the preceding year over those expenses in the second preceding year exceeded the State voluntary limit for the preceding year. He shall make that determination as follows:

(1) He shall compute the dollar amount by which the expenses of each hospital in the State in its accounting period ending in that preceding year exceeded (or was less than) its expenses in its preceding accounting period increased by the voluntary percentage limit (computed under section 102) for the hospital for the accounting period.

(2)(A) He shall compute the sum of the dollar amounts computed under paragraph (1).

(B)(i) For 1979, if the sum is greater than zero, he shall announce that the increase in hospital expenses in the State for the preceding year exceeded the State voluntary limit for that year.

(ii) For 1979, if the sum is equal to or less than zero, he shall announce that such increase did not exceed the State voluntary limit for the preceding year and he shall credit, to a State carryforward account for that State, an amount equal to one-half of the dollar amount of such savings.

(iii) Immediately before making a determination under this subsection for a year after 1979, the amount of any balance in the State carryforward account shall be increased by a percentage equal to the sum of the products, for each hospital in the State, of—

(I) the voluntary percentage limit for the accounting period ending in the year, and

(II) the fraction of the expenses of hospitals in the State for accounting periods ending in the year which are the expenses of the hospital for its accounting period ending in the year.

(C)(i) For a year after 1979, if the sum is greater than zero, he shall apply, against such sum and to the extent of such sum, any balance in the State carryforward account (described in subparagraph (B)(ii)). If, after applying some or all of such balance, the sum is equal to zero, the Secretary shall announce that the increase in hospital expenses in the State did not exceed the State voluntary limit for the preceding year and shall debit, against the State carryforward account of that State, the amount of the account applied. If, after applying all of such balance, the sum is still greater than zero, he shall announce that the increase in hospital expenses in the State for the preceding year exceeded the State voluntary limit for that year and shall reduce to zero the balance of the State carryforward account of the State.

(ii) For a year after 1979, if the sum is equal to or less than zero, he shall announce that the increase did not exceed the State voluntary limit for the preceding year and he shall credit, to the State carryforward account for that State an amount equal to one-half of the dollar amount of such savings for such year.

INDIVIDUAL HOSPITAL PERFORMANCE

SEC. 114. (a) The Secretary, when he computes an individual hospital voluntary percentage limit under section 102, shall determine whether the percent increase in a hospital's expenses in the hospital's accounting period over those expenses in the previous accounting period exceeded the hospital's individual voluntary hospital percentage limit for the period.

(b)(1)(A) For the accounting period ending in 1979, if there was an excess under subsection (a), the Secretary shall inform the hospital that the increase in the hospital's expenses in the accounting period exceeded the hospital's individual voluntary percentage limit for that period.

(B) For the accounting period ending in 1979, if there was no such excess under subsection (a), the Secretary shall inform the hospital that the increase in the hospital's expenses did not exceed the hospital's individual voluntary percentage limit for the period and he shall credit, to a carryforward account for that hospital, an amount equal to one-half of the dollar amount of such savings.

(C) Immediately before making a determination under this subsection for a year after 1979, the amount of any balance in the carryforward account of a hospital shall be increased by a percentage equal to the hospital's individual voluntary percentage limit for the period.

(2) (A) For an accounting period ending in a year after 1979, if there was an excess under subsection (a), the Secretary shall apply, against such excess and to the extent of such excess, any balance in the hospital's carryforward account (described in paragraph (1) (B)). If, after applying some or all of such balance, there is no excess remaining, the Secretary shall inform the hospital that the increase in the hospital's expenses did not exceed the hospital's individual voluntary percentage limit for the accounting period and shall debit, to the carryforward account for that hospital, the amount of the account applied. If, after applying all of such balance, there is still an excess, he shall inform the hospital that the increase in the hospital's expenses in the accounting period exceeded the hospital's individual voluntary percentage limit for that period and shall reduce to zero the balance in the carryforward account of the hospital.

(B) For an accounting period ending in a year after 1979, if there is no excess, he shall inform the hospital that such increase did not exceed the hospital's individual voluntary percentage limit for the period and he shall credit, to the carryforward account for that hospital, an amount equal to one-half of the dollar amount of such savings for such period.

DURATION OF NATIONAL, STATE, AND INDIVIDUAL HOSPITAL VOLUNTARY PERIODS

SEC. 115. (a) The national voluntary period shall be considered to begin with 1979 and to end with the earlier of 1984 or the first year for which—

(1) the Secretary has announced and reported to Congress under section 111(b) that total expenses of hospitals in the United States for the year have exceeded the national voluntary limit for that year, and

(2) the Congress has not, under section 112, disapproved the report for that year.

(b) The voluntary period of a State shall be considered to begin with 1979 and to end with the earlier of 1984 or the first year—

(1) which is the last year of, or is any year after, the national voluntary period (as determined under subsection (a)), and

(2) for which the Secretary has announced under section 113 that total expenses of hospitals in the State for the year have exceeded the State voluntary limit for that State for that year.

(c) The voluntary period of an individual hospital shall be considered to begin with the hospital's accounting period ending in 1979 and to end with the hospital's accounting period ending in 1984, or, if earlier, the first accounting period—

(1) which ends in the last year of, or in any year after, the voluntary period of the State in which the hospital is located (as determined under subsection (b)), and

(2) for which the Secretary has informed the hospital under section 114 that the hospital's expenses in the accounting period have exceeded the hospital's individual hospital voluntary percentage limit for that period.

(d)(1) Subject to paragraph (2), each hospital is subject to a mandatory limit as prescribed under part A of title II for each accounting period (ending before December 31, 1985) which begins after the end of the voluntary period of the hospital (as determined under subsection (c)).

(2) Paragraph (1) shall not apply to a hospital for an accounting period for which there is an exemption under part B of title II.

TITLE II—MANDATORY HOSPITAL COST CONTAINMENT PROGRAM

PART A—ESTABLISHMENT OF MANDATORY PERCENTAGE LIMITS APPLICATION OF MANDATORY LIMITS

SEC. 201. (a) For any accounting period of a hospital subject to a mandatory limit under this part, the average reimbursement payable to the hospital by a

cost payer per admission and the average inpatient charges per admission of the hospital for the period may not exceed the average reimbursement payable to the hospital by the cost payer per admission, or the average inpatient charges per admission of the hospital, respectively, for the base accounting period of the hospital, by a percentage which is greater than the compounded sum of the percentage mandatory limits computed by the Secretary under this part for that accounting period and previous accounting periods of the hospital after the base accounting period.

(b) (1) For purposes of calculating under subsection (a) for the base accounting period the average inpatient charges per admission of a hospital and the average reimbursement payable to the hospital by each cost payer per admission, the inpatient charges of the hospital (and the reimbursement payable to the hospital by each cost payer) for the base accounting period shall (except as provided in paragraph (2)) be reduced by an amount equal to any inpatient charges (or, in the case of a cost payer, any such inpatient charges attributable to that cost payer) for the base accounting period for elements of inpatient hospital services that cease to be furnished in the accounting period subject to the mandatory limit, multiplied by the fraction of the accounting period during which those services are not furnished.

(2) Paragraph (1) shall not apply with respect to inpatient hospital services that have been found inappropriate by the State health planning and development agency for the hospital.

(3) Upon request by a hospital, the State health planning and development agency for the hospital shall make a finding as to the appropriateness of specific health services for purposes of paragraph (2), after requesting the recommendations of the health systems agency for the hospital. The finding of a State health planning and development agency under this paragraph shall not be subject to further review.

(c) (1) Any hospital the sum of the amounts of the uncollectible inpatient charges (as defined in paragraph (2) (A) and of the allowances for inpatient care provided to charity patients (as defined in paragraph (2) (B)) of which in a current accounting period exceeds the sum of the amounts of such charges and allowances in its most recent previous accounting period may, in accordance with such regulations as the Secretary shall prescribe, have its average inpatient charges per admission computed under this Act for the current accounting period by considering as inpatient charges for the current accounting period and the base accounting period only inpatient charges that are not uncollectible inpatient charges and that are not allowances for inpatient care provided to charity patients.

(2) For purposes of paragraph (1)—

(A) the term "uncollectible inpatient charges" means, with respect to inpatient charges imposed by a hospital, inpatient charges to the extent to which the hospital establishes, to the satisfaction of the Secretary, that (i) it has made reasonable efforts to collect them, (ii) any uncollected amounts of such charges are in fact uncollectible, and (iii) there is not substantial likelihood of their future collection, and

(B) the term "allowances for inpatient care provided to charity patients" means, with respect to inpatient charges in an accounting period relating to care provided to patients by a hospital, reductions in the inpatient charges which the hospital establishes, to the satisfaction of the Secretary, it has made in the period because of the indigence or medical indigence of the patients.

CALCULATION OF MANDATORY PERCENTAGE LIMIT

SEC. 202. (a) The Secretary, within six months after the last day of each hospital's accounting period subject to a mandatory limit under this part, shall compute and inform the hospital of its mandatory percentage limit for that accounting period. This mandatory percentage limit—

(1) for such an accounting period which follows an accounting period that was not subject to a mandatory limit under such section, shall be equal to the sum of—

(A) the product of (i) the percentage computed under sections 203 through 206, and (ii) the fraction of the accounting period that occurs in the year in which the accounting period ends, and

(B) the product of (i) the percentage increase in the hospital's expenses in the preceding accounting period over its expenses in the second

preceding accounting period, and (ii) the fraction of the accountng period that occurred in the previous year;

(2) for any other such accounting period (other than an accounting period described in paragraph (3)), shall be equal to the percentage computed under sections 203 through 206; and

(3) for such an accounting period ending in 1985, shall be equal to the sum of—

(A) the product of (i) the percentage increase in the hospital's expenses in the accounting period over its expenses in the preceding accounting period, and (ii) the fraction of the accounting period that occurs in 1985, and

(B) the product of (i) the percentage computed under sections 203 through 206, and (ii) the fraction of the accounting period that occurred in 1984.

CALCULATION OF BASE PERCENTAGE

SEC. 203. The Secretary shall compute a base percentage for each hospital's accounting period subject to a mandatory limit under this part. This base percentage for a hospital's accounting period shall be equal to the sum of—

(1) the percent increase in the wage marketbasket of the hospital (as defined in section 323(4)) for the accounting period, and

(2) the greater of—

(A) the percent increase in the nonwage marketbasket (as defined in section 323(3)) of the hospital for the accounting period, or

(B)(i) for an accounting period that begins before the first calendar quarter beginning after the date of enactment of this Act, 6.5 percent, or

(ii) for any other accounting period, the percent increase of the national nonwage marketbasket estimated and announced under section 101(b) for the twelve-month period beginning with the calendar quarter in which the accounting period began, multiplied by the hospital's adjustment factor (as defined in section 323(5)) for the period.

EFFICIENCY ADJUSTMENT

SEC. 204. Based on the method (developed under section 315(a)) of measuring a hospital's efficiency within a group of hospitals, the Secretary shall assign to each hospital in a group, with respect to each accounting period subject to a mandatory limit under this part, a percentage bonus (or penalty) related to the extent to which the hospital's expenses (adjusted for area wage differentials) for the accounting period of the kind utilized in defining the group norm are less than (or exceed) the group norm, as follows:

(1) If the adjusted expenses are less than 90 percent of the group norm, there shall be a bonus of 1 percentage point.

(2) If the adjusted expenses are equal to or exceed 90 percent of the group norm but are less than the group norm, there shall be a bonus which bears the same proportion to 1 percentage point as the proportion of (A) the percent difference between the group norm and the adjusted expenses, to (B) 10 percent.

(3) If the adjusted expenses are equal to or exceed the group norm but do not exceed 110 percent of the group norm, there shall be no bonus or penalty.

(4) If the adjusted expenses exceed 110 percent of the group norm but do not exceed 130 percent of the group norm, there shall be a penalty which bears the same proportion to 2 percentage points as the proportion of (A) the percent difference between the adjusted expenses and 110 percent of the group norm, to (B) 20 percent.

(5) If the adjusted expenses exceed 130 percent of the group norm, there shall be a penalty of 2 percentage points.

The Secretary shall add the amount of any bonus to (or subtract the amount of any penalty from) the base percentage computed for the hospital for the accounting period under section 203.

ADMISSIONS ADJUSTMENT

SEC. 205. (a) The Secretary shall establish, by regulation, a method for the adjustment of the base percentage (as adjusted under section 204) for the accounting period to reflect changes in number of admissions in the period com-

pared to the number of admissions in a previous accounting period. In promulgating these regulations he shall take into account—

(1) the marginal costs of hospitals associated with changes in admissions in one accounting period compared to a previous accounting period.

(2) shifts in admissions caused by a hospital's entering into (or ending) contracts with health maintenance organizations, and

(3) the impact of appropriate reductions in hospital utilization.

(b) Any hospital that is dissatisfied with an adjustment in its adjusted percentage base under the method established under subsection (a) may apply to the Secretary for an adjustment in such method as it applies to the hospital for an accounting period to the extent it can demonstrate that it has a higher marginal cost for changes in admissions in the accounting period than those assumed under such method.

ADJUSTMENT FOR PRIOR PERFORMANCE

SEC. 206. (a) In order to reflect the hospital's performance during its voluntary period, the Secretary shall assign to the hospital's accounting period a percentage reduction. This percentage reduction, subject to subsection (b)(1), shall be equal—

(1) in the case of the first accounting period of the hospital subject to a mandatory limit under this part, to the percentage by which (A) the percentage increase in the hospital's expenses in the preceding accounting period over those expenses in the second preceding accounting period, exceeded (B) the hospital's voluntary percentage limit (established under section 102) for that preceding accounting period, and

(2) in the case of a succeeding accounting period, to any excess amount which has been carried forward under subsection (b)(2) from a previous accounting period.

(b) In the case of a hospital's accounting period for which the sum of the percentage penalty (if any) under section 204 and the percentage reduction otherwise assigned under subsection (a) would exceed one-half of the base percentage computed under section 203—

(1) the amount of the percentage reduction assigned under subsection (a) for the period shall be limited so that the sum of it and the percentage penalty for the period equals one-half of the base percentage for the period, and

(2) the excess amount shall be carried forward to be assigned as a percentage reduction to the succeeding accounting periods of the hospital subject to a mandatory limit.

(c) The Secretary shall subtract from the base percentage of a hospital (as adjusted under sections 204 and 205)—

(1) in the case of the hospital's first accounting period subject to a mandatory limit, the percentage reduction assigned to the period under this section;

(2) in the case of any succeeding particular accounting period ending in a year (other than in 1985), the sum of—

(A) the product of (i) the percentage reduction assigned to the preceding accounting period under this section, and (ii) the fraction of the particular accounting period that occurred in the preceding year, and

(B) the product of (i) the percentage reduction assigned to the particular accounting period under this section, and (ii) the fraction of the particular accounting period that occurred in the year; and

(3) in the case of a succeeding accounting period ending in 1985, the percentage reduction assigned to the preceding accounting period under this section.

EXCEPTIONS

SEC. 207. (a) On the request of a hospital, the Secretary, in his discretion, shall make further additions to the mandatory percentage limit for an accounting period otherwise computed under this part to allow for higher reimbursement or inpatient charges per admission than would otherwise be permitted. Any such request shall be filed, in such manner and form as the Secretary shall prescribe, with the appropriate agency or organization with which the Secretary has entered into an agreement under section 1816 of the Social Security Act.

(b) The Secretary shall establish, by regulation, guidelines for the grounds for exceptions under subsection (a). Such grounds shall include the following

changes and circumstances which, the hopsital can demonstrate, result in higher reimbursement or inpatient charges per admission than would otherwise be permitted:

(1) A substantial change in the hospital's capacity because of the closing of another health facility in the area of the hospital.

(2) A significant change in capacity or character of inpatient hospital services available in the hospital.

(3) A major renovation or replacement of physical plant.

(4) A significant shift among cost payers and other classes of payers.

(5) A significant increase in the coverage of inpatient hospital services by a cost payer.

(6) Higher expenses associated with the special needs and circumstances (including greater intensity of care) of the hospital because it is a regional tertiary care institution.

(7) The hospital is a sole community hospital which would otherwise be insolvent and the State health planning and development agency for the hospital has determined that the hospital should be maintained.

(8) Such other changes and circumstances as the Secretary finds warrant special consideration.

A hospital may apply for an exception based upon a combination of these factors (no single factor of which would have been sufficient for a separate exception), if each of these factors can be demonstrated to have an appreciable and demonstrable effect on excess hospital expenses.

(c) In applying exceptions described in subsection (b) to individual hospitals, the Secretary shall take into account, as appropriate, (1) the financial solvency of the hospital, and (2) the extent to which the hospital's actions conformed with health plans for the area in which it is located. In determining the financial solvency of a hospital under clause (1), the Secretary shall not take into account amounts related to philanthropy (as defined in section 322(3)).

(d) If a hospital files a request for an exception under this section and the Secretary has not acted on the request within sixty days of its filing, the request for the exception shall be treated as granted.

Part B—Approval of State Mandatory Programs and Exemptions From Mandatory Limits

APPROVAL OF STATE MANDATORY PROGRAMS

Sec. 211. (a) The chief executive of any State may apply to the Secretary for the approval for a year of a State mandatory hospital cost containment program (hereinafter in this section referred to as "the program") established in the State. The Secretary shall approve the program for the year if—

(1) the State mandatory hospital cost containment program was established by statute before January 1, 1979; or

(2)(A) the Secretary determines that the program will be applicable to—

(i) all hospitals in the State and to all revenues or expenses for inpatient hospital services (other than revenues under title XVIII of the Social Security Act, unless approved by the Secretary), or

(ii) at least 75 percent of all revenues or expenses for inpatient hospital services (including revenues under title XVIII of the Social Security Act);

(B) the Secretary receives satisfactory assurances as to the equitable treatment under the program of all entities (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients;

(C) the program does not treat, directly or indirectly, as revenues of any hospital any of the hospital's amounts related to philanthropy (as defined in section 322(3)); and

(D) the Secretary—

(i) determines that for the previous year, if (for accounting periods of hospitals in the State ending in such previous year) the individual hospital voluntary percentage limits (computed under section 102) were increased by 1 percentage point, the Secretary would determine that the sum of the dollar amounts computed under section 113(a)(1) for such previous year would be equal to or less than zero, or

(ii) receives satisfactory assurances that such sum of dollar amounts, computed under section 113(a)(1) for the year, will be equal to or less than zero.

(b) The Secretary, in establishing standards and reviewing applications for approval of State mandatory hospital cost containment programs under this section, shall consult with the National Commission on Hospital Cost Containment (established under section 301).

(c)(1) There shall be exempted from a mandatory limit under part A any accounting period of a hospital in a State which ends in a year in which a State mandatory hospital cost containment program for the State has been approved under this section.

(2) The Secretary may waive requirements for reimbursement under titles V, XVIII and XIX of the Social Security Act for hospitals located in a State with a mandatory hospital cost containment program approved under this section. The request of a State with such an approved program for such a waiver under such titles shall be deemed approved unless the Secretary disapproves the request within 90 days after the date the request is received by the Secretary. The Secretary shall waive such requirements under title XVII of such Act for a year for such a program—

(A) if the program was granted, before the date of the enactment of this Act, a waiver of such requirements with respect to such title under section 402 of the Social Security Amendments of 1967 or section 222 of the Social Security Amendments of 1972, and

(B) if the percent increase in revenues per admissions under such title for the previous year is no greater than the national voluntary percentage limit for that year.

FUNDING OF STATE MANDATORY PROGRAMS

SEC. 212. (a) The Secretary may make grants to States to assist them in planning, establishing, or operating State mandatory hospital cost containment programs.

(b) An application by a State for assistance under this section shall be in such form, submitted in such manner, and contain such information and assurances, as the Secretary may require.

(c) The Secretary shall determine the amount of any assistance provided under this section, and may make payment in advance or by way of reimbursement, and at such intervals and on such conditions as he finds necessary. Subject to appropriations, the Secretary may provide assistance in amounts up to 50 percent of the necessary expenses involved with the planning, establishment, or operation of such a program.

(d) There are authorized to be appropriated for assistance under this section $10,000,000 for the fiscal year ending September 30, 1980, and such sums as may be necessary for each of the three succeeding fiscal years.

EXEMPTION OF HOSPITALS ENGAGED IN CERTAIN EXPERIMENTS OR DEMONSTRATIONS

SEC. 213. The Secretary may exempt accounting periods of a hospital from the application of a mandatory limit under part A if he determines that—

(1) the exemption is necessary to facilitate an experiment or demonstration entered into under section 402 of the Social Security Amendments of 1967, section 222 of the Social Security Amendments of 1972, or section 1526 of the Public Health Service Act, and

(2) the experiment or demonstration is consistent with the purposes of this Act.

PART C—ENFORCEMENT

CIVIL PENALTY

SEC. 221. (a)(1) If the Secretary determines that the average reimbursement payable to a hospital by a cost payer per admission for an accounting period exceeds the mandatory limit (established under part A) for the hospital for the accounting period, the hospital is subject to a civil penalty of 150 percent of the amount by which the reimbursement payable to the hospital by the cost payer for the accounting period would have to be reduced so that the average reimbursement payable to the hospital by the cost payer for that accounting

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period would not exceed the mandatory limit for that accounting period under part A.

(2) If the Secretary determines that—

(A) the average inpatient charges per admission of a hospital for an accounting period exceed the mandatory limit (established under part A) for the hospital for the accounting period, and

(B) subject to paragraph (3)(B), the hospital fails to deposit an amount equal to the amount of such excess charges in an escrow account (established and maintained pursuant to paragraph (4)),

the hospital is subject to a civil penalty of 150 percent of the difference between (i) the amount of the excess described in subparagraph (A), and (ii) subject to paragraph (3)(B), the amount deposited with respect to such excess in the escrow account, multiplied by the fraction (as determined by the Secretary) of the inpatient charges in the period not attributable to cost payers.

(3) A hospital which has established an escrow account pursuant to paragraph (4) and—

(A) withdraws an amount from such account in a manner not permitted under paragraph (4)(B), is subject to a civil penalty in an amount equal to 150 percent of the amount so withdrawn, and

(B) has a balance in such account after the end of its accounting period beginning in 1984, is subject to a civil penalty in an amount equal to the amount remaining in such account.

(4)(A) In order to avoid liability for a civil penalty under paragraph (2), a hospital which has average inpatient charges per admission for an accounting period in excess of its mandatory limit (established under part A) may establish, in a manner prescribed by the Secretary, an escrow account for the deposit of amounts with respect to one or more of the hospital's accounting periods for which the hospital has made excess inpatient charges per admission.

(B) If the Secretary certifies that the average inpatient charges per admission of a hospital for an accounting period subject to a mandatory limit fall below the mandatory limit established under part A for that accounting period, the hospital may withdraw from any escrow account (described in subparagraph (A)) previously established an amount determined by the Secretary to be equal to the product of (i) the amount by which the inpatient charges of the hospital for that accounting period could be increased without causing the hospital's average inpatient charges per admission for that accounting period to exceed the mandatory limit established under part A for that accounting period, and (ii) the fraction (as determined by the Secretary) of those charges not attributable to cost payers.

(b) The civil penalties provided under subsection (a) shall be assessed by the Secretary only after the hospital has been provided written notice and opportunity for a hearing on the record at which the hospital is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the hospital.

(c)(1) A hospital adversely affected by an assessment by the Secretary under this section may obtain a review of such assessment in the United States court of appeals for the circuit in which the hospital is located by filing in such court within sixty days following notification to the hosiptal of the Secretary's final determination as to the assessment a written petition praying that the assessment be modified or set aside. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, and thereupon the Secretary shall file in the court the record in the proceeding as provided in section 2112 of title 28, United States Code. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined therein, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such record a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the assessment of the Secretary and enforcing the same to the extent that such order is affirmed or modified.

(2) No objection that has not been urged before the Secretary shall be considered by the court, unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances.

(3) The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive.

(4) If any party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such

evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify his findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and he shall file such modified or new findings, which findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order. Upon the filing of the record with it, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that the same shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States Code.

(d) (1) Civil penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in the United States district court for the district where the hospital is located. Amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States to the hospital against which the penalty has been assessed.

(2) A determination by the Secretary to assess a penalty under this section shall be final upon the expiration of the sixty-day period referred to in subsection (c) (1) unless the hospital against which the penalty has been assessed files for a review of such assessment as provided in that subsection. Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (c) may not be raised as a defense to a civil action by the United States to collect a penalty assessed under this section.

(e) (1) Each private cost payer shall—

(A) report to the Secretary (or an agency or organization designated by the Secretary) data on charges, total reimbursement payable, and number of admissions and related private reimbursement data for the base accounting period and each subsequent accounting period for each hospital for which it makes payments based on costs of providing services and for which a mandatory limit applies under part A, and

(B) permit the Secretary access to its books and records as necessary to verify such reports.

(2) If a private cost payer fails to make the reports or provide the access required under paragraph (1) or provides incorrect or false information in such reports, the Secretary is authorized to apply to any United States district court for the district in which the cost payer operates, or to any court of general jurisdiction in any State in which the cost payer operates, to enjoin such a violation

CONFORMANCE BY CERTAIN FEDERAL AND STATE PROGRAMS

SEC. 222. (a) Notwithstanding any provision of title XVIII of the Social Security Act, reimbursement for inpatient hospital services under the program established by such title shall not be payable, on an interim basis or in final settlement, to a hospital for an accounting period—

(1) which is subject to a manadatory limit under part A, to the extent that the reimbursement exceeds the mandatory limit prescribed under such part, or

(2) which is exempted from such a limit under section 211 (c) (1) because the hospital is located in a State with an approved mandatory hospital cost containment program, to the extent that the reimbursement exceeds the limit prescribed under such State mandatory hospital cost containment program.

(b) Nowithstanding any provision of title V or XIX of the Social Security Act, payment shall not be required to be made by any State under either such title, nor shall payment be made to any State under either such title, with respect to any amount paid for inpatient hospital services to a hospital for an accounting period—

(1) which is subject to a mandatory limit under part A, to the extent that the amount exceeds such limit prescribed under such part, or

(2) which is exempted from such a limit under section 211 (c) (1) because the hospital is located in a State with an approved mandatory hospital cost containment program, to the extent that the amount exceeds the limit prescribed under such State mandatory hospital cost containment program.

TITLE III—COMMISSION, ADMINISTRATIVE PROVISIONS, AND DEFINITIONS

PART A—NATIONAL COMMISSION ON HOSPITAL COST CONTAINMENT

NATIONAL COMMISSION ON HOSPITAL COST CONTAINMENT

SEC. 301. (a) The Secretary shall establish a National Commission on Hospital Cost Containment (hereinafter in this section referred to as the "Commission").

(b) The Commission shall consist of fifteen members appointed by the Secretary. Of those members—

(1) five shall be individuals representative of hospitals,

(2) five shall be individuals representative of entities that reimburse hospitals, of whom one shall be the Administrator of the Health Care Financing Administration, and

(3) five shall be individuals who are not representatives of either hospitals or of entities that reimburse hospitals.

(c) (1) Except as provided in paragraphs (2) and (3), members shall be appointed for three years.

(2) Of the members first appointed—

(A) five shall be appointed for a term of two years, and

(B) five shall be appointed for a term of one year.

(3) Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of the member's term until the member's successor has taken office.

(d) The Secretary shall appoint one of the members as Chairman, to serve until the expiration of the member's term.

(e) Eight members of the Commission shall constitute a quorum to do business. The Commission shall meet at the call of the Chairman or at the call of a majority of its members.

(f) The Commission shall advise, consult with, and make recommendations to, the Secretary with respect to—

(1) the implementation of this Act,

(2) proposed modifications to the provisions of this Act, and

(3) any other matters that may affect hospital expenses or revenues.

(g) (1) Except as provided in paragraph (2), members of the Commission shall each be entitled to receive the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including traveltime) during which the member is engaged in the actual performance of Commission duties.

(2) Members of the Commission who are full-time officers or employees of the United States shall receive no additional pay on account of their service on the Commission.

(3) While away from their homes or regular places of business in the performance of services for the Commission, members of the Commission, shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code.

(h) The Commission may, subject to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, appoint, fix the pay of, and prescribe the functions of such personnel as are necessary to carry out its functions. In addition, the Commission may procure the services of experts and consultants as authorized by section 3109 of such title.

(i) The provisions of section 14(a) of the Federal Advisory Committee Act shall not apply with respect to the Commission.

PART B—ADMINISTRATIVE PROVISIONS

REGULATIONS AND SHORT ACCOUNTING PERIODS

SEC. 311. (a) The Secretary may prescribe regulations to implement the provisions of this Act and shall determine or estimate any amounts or limits specified in this Act.

(b) The Secretary may make appropriate adjustments in the application of the provisions of this Act with respect to short accounting periods (described in section 321(1)(B)).

HEARINGS AND APPEALS

SEC. 312. (a) Any hospital or payer dissatisfied with a determination made on behalf of the Secretary under part A of title II may obtain a hearing before the Provider Reimbursement Review Board (established under section 1878(h) of Social Security Act and hereinafter in this section referred to as the "Board") if the amount in controversy is $10,000 or more and the request for such hearing is filed within 180 days after notice of the determination.

(b)(1) The provisions of subsections (c), (d), (e), (f), and (i) of section 1878 of the Social Security Act shall apply to hearings provided under subsection (a). In addition, the Board shall have the power to affirm, modify, or reverse any final determination (described in subsection (a)) of a fiscal intermediary or another entity acting on behalf of the Secretary.

(2) After completing a hearing provided under subsection (a) with respect to a determination, the Board shall render its decision on the determination not later than sixty days after the last day of the hearing.

(c) In addition to the members appointed under section 1878(h) of the Social Security Act, the Secretary may appoint up to four additional members to the Board. For every two additional members appointed under this subsection, one shall be representative of providers of services. Those provisions of section 1878(h) of the Social Security Act which relate to compensation and terms of office of members of the Board shall also apply to members appointed under this subsection.

CONSOLIDATED TREATMENT OF CERTAIN HOSPITALS WITH COMMON OWNERSHIP

SEC. 313. (a) Subject to subsection (b) and (c), an organization that totally owns or controls in a State two or more hospitals the accounting periods of which are subject to mandatory limits established under part A of title II, which have the same accounting period, and which were totally owned or controlled by the organization as of the date of the enactment of this Act shall have the limits under such part on average reimbursement per admission and on the average inpatient charges per admission (and any civil penalty thereon under section 221) computed and applied in the aggregate for all such hospitals with the same accounting period in the State, rather than on each such hospital, if—

(1) the organization requests the Secretary, in a timely manner, to have such treatment made, and

(2) the Secretary determines that the organization has provided adequate assurances that the organization will provide, on a timely basis, the data necessary to determine these limits on the hospitals.

(b) A hospital treated on a consolidated basis with another hospital or hospitals under subsection (a) shall have such consolidated treatment discontinued if—

(1) the hospital is no longer totally owned or controlled by an organization which owns or controls the other hospital or hospitals, is no longer subject to a mandatory limit under part A of title II, or no longer has the same accounting period as the other hospital or hospitals; or

(2) the organization requests such discontinuance and the Secretary approves of such disconstinuance.

(c) The Secretary may not grant any exception under section 207 with respect to any hospital that is treated on a consolidated basis with another hospital or hospitals under subsection (a).

IMPROPER CHANGES IN ADMISSION PRACTICES

SEC. 314. (a) No hospital may change its admission practices in a manner which results in—

(1) a significant reduction in the proportion of its patients who have no third-party coverage and who are unable to pay for inpatient hospital services provided by the hospital,

(2) a significant reduction in the proportion of persons admitted to the hospital for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such services,

(3) the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital, or

(4) the refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services.

(b) The Secretary shall monitor, on a periodic basis, the extent of each hospital's compliance with subsection (a).

(c)(1) Upon written complaint by any institution that satisfies paragraphs (1) and (7) of section 1861(e) of the Social Security Act or upon receiving such volume of written complaints or such reasonable documentation from any persons (as the Secretary finds sufficient) that a hospital has changed its admission practices in a manner in violation of subsection (a), the Secretary shall investigate the complaint and, upon a finding by him that the complaint is justified, he may—

(A) exclude the hospital from participation in any or all of the programs established by title V, XVIII, or XIX of the Social Security Act, or

(B) reduce the total amounts otherwise reimbursable to the hospital under title XVIII of the Social Security Act in an amount equal to $2,000 for each of the number of persons who were not admitted as patients because of the change,

or both.

(2) In addition the Secretary may take any other action authorized by law (including an action to enjoin such a violation brought by the Attorney General upon request of the Secretary) which will restrain or compensate for a violation of subsection (a).

(d)(1) An appropriate civil action to restrain an alleged violation of subsection (a) may be brought by a person other than the Secretary, but only if—

(A) 180 days have passed from the date a complaint with respect to that alleged violation has been filed by the person with the Secretary, and

(B) neither the Secretary nor the Attorney General has commenced and is diligently pursuing judicial proceedings or administrative action with respect to the alleged violation.

(2) Any civil action under this subsection shall be brought in the United States district court for the judicial district in which the hospital in question is located, and the district courts of the United States shall have jurisdiction over actions brought under this subsection without regard to the amount in controversy or the citizenship of the parties.

(3) In any action brought under this subsection, the Secretary or the Attorney General, if not a party, may intervene as a matter of right.

(4) The court, in issuing any final order in any action brought under this subsection, may award costs of suit and reasonable fees for attorneys and expert witnesses if the court determines that such an award is appropriate. Any court, in issuing its decision in an action brought to review such an order, may award costs of suit and reasonable fees for attorneys if the court determines that such an award is appropriate.

(e) Nothing in this section shall restrict any right which any person (or class of persons) may have under any other statute or at common law to seek enforcement of this Act or to seek any other relief.

DETERMINATION OF RELATIVE EFFICIENCY OF HOSPITALS AND MEDICARE AND MEDICAID BONUSES FOR EFFICIENCY

SEC. 315. (a) The Secretary shall develop (and may from time to time revise), by regulation, a system of grouping hospitals by appropriate characteristics, such as patient case mix and metropolitan or nonmetropolitan setting. He shall establish (and may from time to time revise), by regulation, a method of measuring efficiency within each group that provides for setting a group norm, defined in terms of all or certain hospital expenses (adjusted for area wage differentials). In determining individual hospital efficiency under the method, the Secretary may take into account systemwide savings attributable to lower hospitl inpatient utilization per capita in the area in which the hospital is located. If the hospital provides care to a greater percentage of patients sixty-five years of age or older than the average percentage for its group, the Secretary shall adjust (to the extent the method for determining the relative efficiency of the hospital does not otherwise take this into consideration) the amount of the hospital's expenses to take into consideration the higher average costs assocaited with care for paients sixty-five or older to the extent of such excess percentage.

(b)(1) The Secretary may, in his discretion, provide for a bonus in the amount otherwise reimbursable to a hospital under title XVIII or under a State plan approved under title XIX of the Social Security Act to reflect that the hospital, as determined under subsection (a), is more efficient for an accounting period than the group norm for hospitals in its group. Such a bonus may not exceed the lesser of—

(A) one-quarter of the total amount of the savings under such title or plan of the hospital below the norm, or

(B) the product of (i) 5 percent of the amount of the expenses for the group norm per unit of measurement, and (ii) the number of units of measurement associated with the hospital's performance.

(2) In addition, the amount of a bonus under this subsection may not exceed such amount as the hospital can demonstrate to the satisfaction of the Secretary will be used—

(A) to finance the hospital's outpatient deficit for the accounting period with respect to which the bonus is made;

(B) to reduce the long-term debt of the hospital; or

(C) to fund other uses meeting such guidelines as the Secretary determines will not increase the operating costs of the hospital and are in the public interest,

and a bonus shall not be available for the purpose described in subparagraph (A) unless the hospital establishes to the satisfaction of the Secretary that it has made reasonable efforts to collect all revenues due for its provision of outpatient services, that any uncollected amounts are in fact uncollectable, and that there is no substantial likelihood of future collection. For purposes of subparagraph (C), a hospital's outpatient deficit for an accounting period is the amount by which its allowable costs attributable to the provision of outpatient hospital services (not including emergency room services) in the accounting period exceed its revenue attributable to such services, as determined in accordance with standards and procedures prescribed by the Secretary.

(3) Any bonus provided under this subsection shall be additional to any other reimbursement provided under such titles and shall not be included as reimbursement for purposes of computing the mandatory limit on the hospital under part A of title II.

(4) Bonuses payable pursuant to this section shall be paid, in appropriate proportions, from the Federal Hospital Insurance Trust Fund (established under section 1817 of the Social Security Act) and under a State plan approved under title XIX of such Act.

(5) In exercising his discretion under this section, the Secretary shall take into account (A) the degree to which a hospital has been more efficeint than other hospitals in its group, and (B) the existence of a similar bonus under any State mandatory hospital cost containment program to which the hospital is subject.

(6) The Secretary may not provide, in any fiscal year, for more than $50,000,000 in bonuses to hospitals under this section.

SUNSET PROVISION

SEC. 316. (a) Except as otherwise provided in this Act, the provisions of this Act relating to—

(1) The national voluntary percentage limit shall not apply to years after 1983;

(2) individual hospital voluntary percentage limits shall not apply to accounting periods of hospitals beginning in any year after 1984;

(3) Federal mandatory limits on individual hospitals shall not apply to accounting periods of hospitals beginning in any year after 1984; and

(4) medicare and medicaid bonuses under section 315(b), shall apply only with respect to accounting periods of hospitals ending after December 31, 1979, and before January 1, 1985.

(b)(1) Section 314 shall not apply to changes in admissions practices occurring after December 31, 1984.

(2) Paragraph (1) does not preclude the exclusion or reduction provided in section 314(c)(1) with respect to improper changes in admission practices occurring before January 1, 1985.

(c) The National Commission on Hospital Cost Containment shall be established under section 301 not earlier than October 1 of the year in which this Act is enacted and shall be terminated on March 1, 1985.

Part C—Definitions

GENERAL DEFINITIONS

Sec. 321. For purposes of this Act:

(1) The term "accounting period" means—

(A) except as provided in subparagraph (B)—

(i) in the case of a hospital participating in the program established by title XVIII of the Social Security Act, the period of twelve consecutive calendar months utilized as the reporting period for reimbursement purposes under that program,

(ii) in the case of a hospital not participating in the program established by title XVIII of the Social Security Act, a calendar year, or, if requested by the hospital, such other period of twelve consecutive calendar months as the Secretary may approve, and

(B) in the case of a hospital whose period under subparagraph (A) is changed from one twelve-month period to another, such shorter period as the Secretary may establish.

(2) (A) The term "admission" means the formal acceptance by a hospital of an inpatient, excluding newborn children (unless retained after discharge of the mother) or a transfer within or among inpatient units of the hospital.

(B) In the case of the admission of an individual whose inpatient hospital services are to be reimbursed in part by more than one cost payer, the admission shall be attributed to the cost payer which is to reimburse for such services furnished before any such services are furnished for which other cost payers are to reimburse.

(3 The term "base accounting period" means a hospital's last accounting period not subject to a mandatory limit under part A of title II.

(4) The term "cost payer" means—

(A) a Federal or State program, or

(B) a carrier (as defined by section 1842(f)(1) of the Social Security Act),

that reimburses a hospital for inpatient hospital services on a basis related to the hospital's costs in furnishing those services or on any other basis other than inpatient charges, and the term "private cost payer" means a cost payer described in subparagraph (B).

(5) The terms "health systems agency" and "State health planning and development agency" mean, for a hospital, such agencies as designated under sections 1515 and 1521, respectively, of the Public Health Service Act for the area or State, respectively, in which the hospital is located.

(6) The term "hospital", with respect to any period, means an institution (or distinct part of an institution if the distinct part participates in the program established by title XVIII of the Social Security Act) that satisfies paragraphs (1) and (7) of section 1861(e) of the Social Security Act during all of the period and has satisfied those conditions during the preceding thirty-six months, but does not include, except for purposes of section 315(a), any such institution if it—

(A) had an average duration of stay of thirty days or more during the preceding thirty-six months,

(B) derived 75 percent or more of its inpatient care revenues from one or more—

(i) health maintenance organizations (as defined in section 1301 (a) of the Public Health Service Act) or

(ii) other providers of health care which provide ambulatory and inpatient health services on a prepaid basis to individuals enrolled with such providers to receive such services on such basis,

during the preceding twelve months,

(C) (i) is located in a rural area and (ii) had average annual admissions of four thousand or less during the preceding thirty-six months.

(D) does not impose charges or accept payments for services provided to patients,

(E) is a psychiatric hospital (as described in section 1861(f)(1) of the Social Security Act), or

(F) is a Federal institution during any part of the period.

For purposes of subparagraph (C), the term "rural area" includes an area which is either outside an urban area (as defined by the Bureau of the

Census) or outside a Standard Metropolitan Statistical Area (as determined by the Office of Management and Budget).

(7) The term "inpatient hospital services" has the meaning assigned by section 1861(b) of the Social Security Act, but includes in addition the services specified in section 1861(b)(5) of that Act.

(8) The term "Secretary" means the Secretary of Health, Education, and Welfare.

(9) the term "State" means each of the fifty States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(10) The term "supervisor" has the meaning assigned by section 2(12) of the National Labor Relations Act.

(11) The term "United States" means the geographic area consisting of all the States.

DEFINITIONS RELATING TO CHARGES, EXPENSES, AND REIMBURSEMENT

SEC. 322. For purposes of this Act:

(1) The term "inpatient charges" means charges (as defined by section 405.452(d)(4) of title 42, Code of Federal Regulations, as in effect on the date of the enactment of this Act) for inpatient hospital services.

(2) The term "reimbursement payable to a hospital by a cost payer" means the sum of—

(A) the amounts (other than the coinsurance or deductible amounts of another entity) payable by the cost payer to the hospital for inpatient hospital services, and

(B) the amounts payable by an individual or other entity to the hospital for inpatient hospital services if the individual's expenses for those services are payable in part by the cost payer, to the extent that those amounts are calculated as a portion of the costs or other basis on which the amounts payable by the cost payer are determined, except that amounts payable by a program established under title V, XVIII, or XIX of the Social Security Act shall be determined without regard to adjustments resulting from the application of sections 405.415(d)(3), 405.415(f), 405.455(d), and 405.460(g) of title 42, Code of Federal Regulations.

(3) The term "amounts related to philanthropy" means, with respect to a hospital, any amounts which are attributable to—

(A) a door designed or restricted grant, gift, or income from an endowment, as defined in section 405.423(b)(2) of title 42 of the Code of Federal Regulations;

(B) a grant or gift, or income from such a grant or gift, which is not available for use as operating funds because of its designation by the hospital's governing board;

(C) a grant or similar payment which is made by a governmental entity and which is not available, under the terms of the grant or payment, for use as operating funds;

(D) the sale or mortgage of any real estate or other capital asset of the hospital which the hospital acquired through a gift or grant and which is not available for use as operating funds under the term of the gift or grant or because of its permanent designation by the hospital's governing board; and

(E) a depreciation fund which is (i) created by the hospital in order to meet a condition imposed by a third party for the third party's financing of a capital improvement of the hospital, and (ii) is used exclusively to make payments to such third party for the financing of the capital improvement.

(4) The term "wages" has the same meaning as under the Fair Labor Standard Act of 1938.

DEFINITIONS RELATING TO MARKETBASKET INCREASES

SEC. 323. For purposes of this Act:

(1) The term "percent increase in the national hospital nonwage marketbasket" means, for a twelve-month period, the sum of the products of—

(A) the average percentage increase in the United States in the price of each appropriate class (as determined by the Secretary) of

goods and services (other than wages described in paragraph (2)(A)) in the period over the price of the class in the preceding twelve-month period, and

(B) the average fraction (as computed by the Secretary from time to time) of the expenses of hospitals in the United States attributable to that class.

(2) The term "percent increase in the national hospital wage marketbasket" means, for a year, the product of—

(A) the average percenetage increase in the wages paid in the year over the wages paid in the preceding year per employee per hour to employees (other than to doctors of medicine or osteopathy and to supervisors) of hospitals in the United States, and

(B) the average fraction (as computed by the Secretary from time to time) of the expenses of hospitals in the United States attributable to such wages.

(3) The term "percent increase in the nonwage marketbasket" means, for an accounting period of a hospital, the sum of the products of—

(A) the average percentage increase in the United States (or in the area or State in which the hospital is located, if data for the hospital's area or State are available) in the price of each appropriate class (as determined by the Secretary) of goods and services (other than wages described in paragraph (4)(A)) in the period over the price of the class in the preceding accounting period, and

(B) the fraction (as computed by the Secretary from time to time) of the hospital's expense attributable to the class.

(4) The term "percent increase in the wage marketbasket" means, for a hospital for an accounting pereiod, the product of—

(A) the average percentage increase in the wages paid in the period over the wages paid in the preceding period per employee per hour to employees (other than to doctors of medicine or osteopathy and to supervisors) of the hospital (or zero, if there are not sufficient data to make a reasonable estimate), and

(B) the average fraction (as computed by the Secretary from time to time) of the hospital's expenses attributable to such wages.

(5) The term "adjustment factor" means, for a hospital for an accounting period, a fraction with—

(A) the numerator equal to the sum of the fractions of the hospital's expenses (described in paragraph (3)(B)) attributable to classes of goods and services described in such paragraph, and

(B) the denominator equal to the sum of the average fractions of expenses of hospitals in the United States, as estimated and announced under section 101(b)(2) before the calendar quarter in which the accounting period begins.

DEFINITIONS RELATING TO POPULATION CHANGES

SEC. 324. For purposes of this Act:

(1) The term "percent change in area population" means, for an accountin period of a hospital, if the hospital is located—

(A) in a Standard Metropolitan Statistical Area (as determined by the Office of Management and Budget), the greater of (i) zero, or (ii) the percentage change in the size of the population of the Area in the year preceding the year in which the accounting period ends over the size of the population of such Area in the second preceding year, or

(B) outside such an Area, the greater of (i) zero, or (ii) the percentage change in the size of the population of the county or county equivalent area (as recognized by the Bureau of the Census) in which the hospital is located in the year preceding the year in which the accounting period ends over the size of the population of such county or area in the second preceding year.

(2) The term "percent increase in the national population" means, for a year, the percentage by which the size of the population in the United States in the year exceeds the size of the population of the United States in the preceding year.

I. Legislative Background

Legislation to control hospital costs, H.R. 2626, was introduced on March 6, 1979, by Mr. Rangel, Chairman of the Subcommittee on Health of the Committee on Ways and Means, and Mr. Waxman, Chairman of the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce. A joint hearing was conducted by the two subcommittees on March 12, 1979. The Subcommittee on Health and the Environment held further hearings on hospital cost containment on April 2, 9, and 30, and May 21 and 23, 1979. The bill was reported with amendments by the Committee on Ways and Means on August 1, 1979. The bill was considered in open session by the Subcommittee on Health and the Environment on September 6, and was tabled by the Subcommittee. H.R. 2626 was brought before the Committee on Interstate and Foreign Commerce on September 19 and ordered reported by a vote of 23 to 19 on September 26, 1979.

II. Summary of the Bill

OVERVIEW

The bill provides for a voluntary cost containment program under which provision is made for establishing national, state and individual hospital voluntary limits on the annual rate of increase in hospital expenses. The voluntary limits would be calculated so as to reflect increases in the actual rate of inflation. However, hospitals would be guaranteed for 1979 a national voluntary limit no lower than 11.6 percent (the same as the goal of the hospital industry's own "Voluntary Effort.")

If hospital expenses nationally increase more than the national voluntary percentage limit, the Secretary would determine whether hospitals collectively within a State met their State voluntary percentage limit and, if not, whether individual hospitals met their own individual voluntary limits. If the National, State and individual limits are not met, a hospital would become subject to mandatory limits on annual increases in its inpatient revenues.

Any mandatory limits imposed under this bill would expire on December 31, 1984.

VOLUNTARY HOSPITAL COST CONTAINMENT PROGRAM

Before April of each year (beginning with 1980) the Secretary of HEW would be required to promulgate a national voluntary limit for the percentage increase in total hospital expenses incurred during the previous calendar year. (For 1979, the limit could not be lower than 11.6 percent). The bill provides that the voluntary limit will be composed of the following four components:

(1) The actual percentage increase in the average hourly wage rate and wage-related expenses for non-supervisory employees;

(2) The average percentage increase nationally in the price of a marketbasket of other goods and services hospitals purchase;

(3) An allowance for population growth; and

(4) A 1-percent allowance for "net intensity."

Before July 1 of each year beginning in 1980, the Secretary would determine whether the increase in total hospital expenses has exceeded the national voluntary percentage limit for the previous year. Once announced the mandatory program would go into effect unless disapproved by both Houses of Congress within 45 days of the Secretary's determination or unless disapproved by one House of Congress and the other House does not act to approve the program. If the Secretary determines that hospitals failed to meet the national limit, the Secretary would then apply a State and individual percentage limit, calculated for each hospital. Hospitals in a State which, collectively, meet their State voluntary percentage limits would not be subject to mandatory controls. Even if the hospitals in a State collectively exceed the state limit, those individual hospitals which do not exceed their own individual voluntary percentage limits would be exempt from mandatory controls.

In calculating the voluntary limits for each hospital, the Secretary would use the same components which are part of the national limit except that adjustments would be made to more nearly reflect the individual circumstances of the hospital by taking into account: (1) a hospital's own wage-related expenses; (2) a hospital's own proportion of total expenses spent on non-wage marketbasket items; (3) the area of State increase, if available, in the price of items in a hospital's non-wage marketbasket; and (4) the area's population increase.

For the purpose of calculating voluntary and mandatory hospital limits, the Secretary would announce quarterly his projection of the component of the limit that reflects the national price increase in the marketbasket of goods and services (other than nonsupervisory labor). A hospital would be guaranteed a limit based on the estimate made immediately before the calendar quarter during which the hospital's accounting period began, even though actual inflation in these goods and services turned out to be lower than estimated.

National, State and individual voluntary limits would reflect a carry-forward of one-half of the amount by which hospital expenses were lower than the applicable voluntary limits in previous years.

MANDATORY HOSPITAL COST CONTAINMENT PROGRAM

Once a hospital becomes subject to the mandatory provisions of the bill, mandatory limits would be applied to the percentage increase in the hospital's inpatient revenues per admission (rather than the hospital's total expenses as under the voluntary program) over its inpatient revenues per admission in its base accounting period (the last period under the voluntary program). Appropriate reductions would be made in the revenues and cost for the base accounting period to adjust for hospital inpatient services that were discontinued. This reduction would be waived if the appropriate state health planning and development agency (SHPDA) determined that the services should be discontinued.

The mandatory limit would be composed of the following:

(1) The percentage increase in the actual average hourly wage rate and wage-related expenses for non-supervisory employees;

(2) The average national percentage increase in the price of other goods and services purchased by hospitals (if available, area or State price data would be used);

(3) A graduated efficiency adjustment which could result in a "bonus" or "penalty";

(4) An adjustment to reflect the increase in expenses that occurred in the year prior to the year the hospital becomes subject to the mandatory program; and

(5) For the first and last years under the mandatory program, an adjustment to reflect the extent to which a hospital's accounting period differed from the calendar year.

Hospitals would be notified of their mandatory limit within 6 months of the end of their accounting period.

An adjustment would be made (under a method established by regulation) to the calculation of a hospital's mandatory limit to take into account changes in admissions. In promulgating the admissions adjustment regulation, the Secretary would be required to consider the marginal costs of changes in admissions in 1 year compared to a previous year, shifts in admissions due to contracts with health maintenance organizations, and the impact of appropriate reductions in hospital utilization. A hospital dissatisfied with an admissions adjustment could apply to the Secretary for an exception if higher marginal costs could be demonstrated.

The bill would require the Secretary to establish, by regulation, guidelines for the grounds for exceptions to the mandatory limit calculated for the hospital. These grounds for exceptions would include the following: (1) substantial change in the hospital's capacity because of the closing of another health facility in the area; (2) significant changes in hospital capacity or in the character of inpatient services; (3) major renovation or replacement of physical plant; (4) significant shifts among cost payers and other classes of payers; (5) significant increases in the coverage of inpatient hospital services by a cost payer; (6) higher expenses associated with special needs and circumstances of regional tertiary care institutions; (7) the hospital is a sole community hospital that would otherwise be insolvent but which has been found by the appropriate health planning agency to be needed; and (8) other factors that the Secretary finds warrant special consideration.

If revenues exceeded the mandatory limit, the hospital would be required to place the excess revenues in an escrow account. The hospital could draw on the escrow account in future years if its revenues were below the mandatory limit. A hospital's refusal to comply with the escrow requirement would result in a civil penalty on the hospital of 150 percent of the excess revenues.

Exempted from the provisions of the bill are (a) new hospitals; (b) hospitals with an average length of stay of 30 days or more; (c) hospitals in non-metropolitan areas and in rural parts of metropolitan areas with 4,000 or less admissions annually; (d) hospitals of health maintenance organizations or of other prepaid providers of health care; (e) hospitals that do not impose charges or accept payments for services provided to patients; (f) psychiatric hospitals; and (g) Federal hospitals.

The Secretary would be authorized to exempt from the mandatory program hospitals engaged in certain Federal demonstrations or experiments. In addition, all hospitals in States with effective mandatory cost containment programs would be exempted from the Federal mandatory program if the State program met certain specified criteria. State mandatory programs established by statute by January 1, 1979, would be deemed to meet all criteria for exemption. The Secretary would be authorized to waive Medicare reimbursement requirements in States with approved mandatory cost containment programs.

The bill would authorize the Secretary to make grants to States to assist them in planning, establishing or operating State mandatory cost containment programs; and would authorize the appropriation for this purpose for $10 million for fiscal year 1980 and such sums as may be necessary for the 3 succeeding fiscal years. Such grants could provide up to 50 percent of the necessary expenses of the State program.

A hospital would be prohibited from adopting changes in admission practices detrimental to consumers. Wherever the Secretary finds that such prohibited practices have occurred, he would be authorized to exclude the hospital from Medicare and Medicaid or reduce payments made by Medicare (but only after the hospital has had the opportunity to exhaust available administrative and judicial remedies). Any person could commence a civil action against a hospital alleged to be in violation of this prohibition if the Secretary and the Attorney General fail to take appropriate action.

Where a hospital increases its volume of charity care and care for patients from whom inpatient charges are uncollectible, provision is made in the bill for an adjustment in the computation of its mandatory limits to assure that such hospital would not be penalized because of the change in volume of its charity care or bad debts.

Hospitals would have the opportunity for a hearing before the Provider Reimbursement Review Board (established by section 1878 of the Social Security Act) on determinations made on behalf of the Secretary under the mandatory program if the amount in controversy is $10,000 or more. The Secretary would be authorized to appoint up to four additional members to the board for this purpose.

OTHER PROVISIONS

The bill would authorize the Secretary to provide a reimbursement bonus under Medicare and Medicaid to hospitals, subject to the voluntary or mandatory cost containment programs, that have kept their expenses below the average expenses of a group of similar hospitals. This bonus could be as large as one-quarter of the difference between the hospitals' expenses and the group average, but in no case could it exceed 5 percent of the group average or the amount which could be used for certain approved uses. The total amount of bonuses provided in any one fiscal year could not exceed $50 million.

The bill would establish a National Commission on Hospital Cost Containment composed of fifteen members appointed by the Secretary. The Commission would advise, consult with, and make recommendations to the Secretary, with respect to implementation of the Act, proposed modifications to it, and any other matters affecting hospital expenses or revenues.

III. Cost of Legislation

As reported by the committee, H.R. 2626 provides authorizations of appropriations for fiscal year 1980 of $10 million to support the planning, establishment and operation of State mandatory hospital cost containment programs, and of such sums as may be necessary in each of the three succeeding fiscal years. Additionally, the bill authorizes payments of bonuses under Medicare and Medicaid to efficient hospitals whose costs are lower than those of similar institutions. Total bonus payments in any year are limited to a maximum of $50 million.

H.R. 2626 results in a net savings, however, considerably in excess of the amounts authorized by the legislation. Those savings are indicated in detail in the cost estimate provided by the Congressional Budget Office (included in a later section of this report).

IV. Background and Need for Legislation

Inflation is one of the most serious problems facing our nation today. Of the major sectors fueling inflation, rising hospital costs have been, and continue to be, one of the most serious inflation problems in the economy. Between 1975 and 1977, hospital costs increased between 14 and 20 percent annually—more than two times the increase in the Consumer Price Index. If health care prices had simply held even with the inflation rate of other items in the Consumer Price Index, the annual CPI inflation rate would have been 5.8 percent in that 3-year period—not 6.1 percent. Action must be taken to moderate the rapid increase in hospital expenditures if we are to restrain inflation.

Not only is hospital cost containment necessary to restrain inflation but it is now generally regarded to be a primary objective of health care policy. That is essential if we are to expand access to medical care and to assure a more equitable distribution of health care resources.

As hospital costs have risen, and particularly as these costs have been translated into a public burden through significantly expanded government budgets, widespread concern has been expressed about the need to restrain these costs. This concern about steadily rising hospital costs is warranted in view of the data on health expenditures.

National health expenditures have increased for nearly 50 years in aggregate terms, on a per capita basis, and as a percent of the Gross National Product (GNP). Estimates for fiscal year 1977 indicate that total expenditures amounted to $162.6 billion, or $737 per capita. This amount represents 8.8 percent of the GNP. Expenditures for hospital care are the largest component of national health expenditures, reaching an estimated $65.6 billion in fiscal year 1977 (or about 40 percent of total expenditures).

Expenditures for hospital care have risen annually at double-digit rates for a decade. During fiscal year 1965, the year prior to enactment of Medicare and Medicaid, expenditures for hospital care amounted to nearly $13.2 billion. Within 5 years, the annual outlay had almost doubled to $25.9 billion and by fiscal year 1977, expenditures had risen almost five times to $65.6 billion.

Hospital expenditures have accounted for a consistently increasing proportion of national health expenditures rising from 30.7 percent

of the total expenditures in fiscal year 1950 to 33.8 percent in fiscal year 1965 and 40.4 percent in fiscal year 1977.

The growth in hospital care expenditures has been financed largely through increases in health insurance benefits and increases in public programs paying for hospital care, most notably Medicare and Medicaid. By fiscal year 1977, these sources paid 94.1 percent of the Nation's hospital bill, with private health insurance paying an estimated 36.6 percent, public programs paying 55.2 percent, and philanthropy and industrial programs paying 2.3 percent. Direct payments by patients accounted for 5.9 percent.

These rising hospital costs exact a heavy toll on all segments of the population but none more so than the elderly and the poor whose limited resources, greater need for medical care, and dependency on public programs makes them particularly vulnerable to the effects of health care inflation. However, the impact on other population groups is also significant since the average individual pays heavily for rising hospital costs through increased out-of-pocket expenditures during hospitalization, increased private health insurance premiums and higher Federal, State and local government taxes.

The impact of rising hospital costs on State and local government budgets resulting from increased Medicaid costs, higher insurance premiums for government employees and higher operating costs for State, county and municipal hospitals has also been severe. Direct State and local government spending for hospital care has increased from $4.2 billion in 1969, to an estimated $10 billion in 1979 (an increase of 240 percent); and it is expected to reach $15.8 billion in 1984 if present rates of increase continue.

The impact on the Federal budget has been equally substantial. Federal hospital expenditures for Medicare and Medicaid in 1969, for example, were $5.2 billion. By 1979, Medicare and Medicaid hospital expenditures had increased by 380 percent to $24.9 billion. By 1984, these expenditures are expected to reach $47.6 billion. In the aggregate, all Federal expenditures for hospital care have increased from $7.7 billion in 1969 to $33.1 billion in 1979, and are likely to reach $60.6 billion in 1984 at current rates of increase. Immediate action is needed to moderate these increases.

The legislation responds to this need by providing incentives to the hospital industry to intensify its voluntary efforts to contain the rate of increase in total hospital expenses and to States to undertake the kind of state cost containment programs that have been successful. If those efforts fail it would put in place a mandatory cost containment program to assure that the cost containment limits are met.

V. Committee Proposal

Title I. Voluntary Hospital Cost Containment Program

Part A—Establishment of Volunary Percentage Limits

National voluntary percentage limit.—The Committee's proposal would require the Secreary of Health, Education and Welfare, to promulgate, before April of each year (beginning with 1980), a national voluntary percentage limit for the percentage increase in total

hospital expenses incurred during the previous calendar year. The national voluntary percentage limit would have four basic components: (1) an allowance for the actual percentage increase in wages of all non-supervisory hospital workers; (2) the average percentage increase nationally in the price of goods and services purchased by hospitals; (3) a population allowance and (4) an allowance for the net increase in intensity.

Prior to the begininng of each year, the Secretary would estimate and announce for that year the rate of increase in the price of goods and services purchased by hospitals (excluding non-supervisory wages). The actual rate of increase in these goods and services, which would be determined after the end of the year, would be used in calculating the limit to the extent it is higher than the earlier estimate.

The reported bill would further provide that, regardless of the percentage limit resulting from the calculation, for calendar year 1979 hospitals would be guaranteed a national voluntary limit of at least 11.6 percent.

The national voluntary limit is designed to reflect those factors and variables which should be taken into account in order to establish an equitable limit on increases in hospital expenditures.

The actual increase nationally in non-supervisory wages would be used in the calculation of the national voluntary limit. The Committee believes that it is necessary to "pass-through" the actual rate of increase to avoid forcing low paid hospital workers to bear the brunt of cost containment efforts. Wage-related expenses (including expenses relating to social security taxes, unemployment compensation, workmen's compensation, and fringe benefits) are not included in the pass-through because they are reflected in the hospital market basket.

The Committee recognizes that labor costs represent a major portion of hospital costs. However, non-supervisory wages have not been increasing as rapidly as the costs of other goods and services that hospitals purchase. The Committee does not expect a wage pass-through to result in a more rapid increase in wages or in a change in the collective bargaining position of a hospital relative to its employees.

The Congressional Budget Office in a recent report came to a similar conclusion:

> With respect to the question of whether wages might increase more rapidly under a pass-through than they would in the absence of a cost containment program, it seems probable that they would not. The wage pass-through would do nothing to stimulate wage increases. For the most part, hospitals would be left with the same incentive as before in seting wages.

The calculation of the limit on expenses also recognizes that certain costs are not directly within the control of the hospital. Consequently, the national limit includes a national marketbasket component to allow for cost increases resulting from inflation in the general economy. This marketbasket would be constructed to reflect the various kinds of goods and services purchased by hospitals and the proportion of hospital budgets nationally attributable to each of the kinds of goods and serv-

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ices. The American Hospital Association (AHA) has worked closely with the Department of Health, Education, and Welfare in developing the marketbasket, and the Committee encourages the continuation of such cooperation in the refinement of the components and the development of more appropriate price indices and forecasting methods. The weights representing the proportion of hospital budgets spent on each category of goods and services are initially to be those recommended by the AHA and should be revised as necessary in later years. The legislation is purposely designed to permit the administrative flexibility necessary for such future refinement.

Because of increases in the population, hospitals will necessarily be providing more services. Accordingly, the calculation of the national voluntary limit would reflect the rate of increase in the total population. The Committee believes that this population growth allowance is ample to allow for increased hospitalization since hospital admissions and patient days are increasing at a rate substantially slower than the growth in total population. During 1978 total admissions for all patients were up 0.4 percent and inpatient days were up 0.1 percent according to the American Hospital Association Panel Survey data. At the same time the population increased nationally about 0.85 percent.

The allowance included in the bill for increases in intensity of services is a net figure and is equal to 1 percent. The Committee recognizes that hospitals are continually providing new services (e.g., because of new technology) but also believes that hospitals are capable of offsetting the higher costs resulting from these additional services through improved productivity or economies of scale. The Committee believes that this net intensity allowance is adequate to allow the maintenance of high quality care. The experience of several States with effective cost containment programs, where the net intensity factor has been well below 1 percent but high quality care has been maintained, has demonstrated this.

Individual hospital voluntary percentage limits.—Should hospitals fail to meet the national voluntary percentage limit with the consequence that state or individual hospital voluntary limits apply, the reported bill provides for the calculation of limits which more fully take into account the unique circumstances of individual hospitals. Accordingly, the limit for an individual hospital would be based on the same four components as the national limit with the following exceptions: (1) the hospital's wage factor would be based on its own increases in nonsupervisory wages during the year and its own proportion of total expenses spent on such workers; (2) the hospital's marketbasket would reflect the hospital's own proportion of expenses in different cost categories; (3) area or state marketbasket price indices rather than national indices would be used whenever adequate data are available; (4) the population allowance would be based on the rate of increase in the total population in the SMSA, or county in which the hospital is located, rather than national data; (5) to the extent that a hospital so requests, a pass-through would be allowed for the cost of providing care to charity patients and patient bills that are uncollectable; (6) to the extent that a hospital so requests, a pass-through would be allowed for the new capital-related expenses (in-

cluding depreciation and interest) related to capital expenditures which (a) significantly increase bed capacity or significantly expand services, capacity, or both and (b) have been approved by the State health planning and development agency; and (7) to the extent that a hospital so requests, a pass-through would be allowed for patient care and teaching expenses related to a major expansion of a medical teaching program.

As in the case of the national limit, hospitals would have, prior to the beginning of their accounting period, the benefit of an estimate of the increase in the non-wage marketbasket during their accounting period which would serve as a guaranteed minimum increase in calculating their individual limit even if the actual rate of increase in inflation during that period were to be lower. In order that the estimate correspond as closely as possible to a hospital's accounting period, the Secretary would be required to announce marketbasket estimates before the beginning of each calendar quarter for the 12-month period beginning that quarter. A hospital would have as a guaranteed minimum, the estimate announced for the quarter in which its accounting period begins. (For accounting periods that begin before quarterly marketbasket estimates are first made, the minimum guaranteed marketbasket would be 6.5 percent.) The estimate would be adjusted by a factor to correct for any difference between the proportion of the hospital's expenses that are for non-wage related expenses and the average of such proportion nationally.

The actual rate of increase in the marketbasket experienced during the hospital's accounting period would be used (if it is not less than the announced estimate) in calculating the hospital's limit.

In substituting area or state price data for national marketbasket data, the Committee expects the Secretary to do so only when reliable data is available. The Committee also expects that the data sources used would be as consistent as possible, preferably uniform, and that use of such data would not substantially affect any savings because of a "balancing effect" of using price data which is both higher and lower than the national data.

The individual hospital voluntary limit provides for a passthrough for increases in expenses for charity care and for patient care expenses which are determined to be uncollectable (which terms would be defined as under medicare policy). The Committee believes that it would be undesirable to provide any disincentives for hospitals to increase their proportion of care provided to charity patients and would want to support the efforts to assure that hospitals comply with the requirements for the provision of charity care under the Hill-Burton program. Since, however, information on expenses related to charity care and bad debts is not readily available on medicare cost reports and hospitals would have to submit additional information, these pass-throughs would be provided for only at the option of an individual hospital.

A hospital can also request the exclusion of capital-related expenses (including depreciation, interest and return on equity) which have not been included in the previous accounting period and result from approved capital expenditures which significantly increase bed capacity or expand services. While the Committee would expect the Secretary

to define what significant increases or expansion would be, the Committee would not expect each increase in bed capacity or each increase in the volume of services for which a certificate of need is required to be eligible for this exclusion. The Committee would clearly view a 10 percent increase in bed capacity or a 25-percent increase in the volume of services to be significant.

A hospital is also permitted to pass-through patient care and teaching expenses related to a major expansion of a teaching program. The Committee would view a major expansion to include the establishment of a new residency program in an approved specialty or a 25-percent increase in the total number of positions in an existing residency program.

The hospital's individual limit would be used in determining whether the hospitals in a state collectively met the voluntary percentage limits for hospitals in the State.

PART B—REVIEW OF PERFORMANCE DURING VOLUNTARY PERIOD

National hospital performance.—Before July 1, 1980, and before July 1 of each succeeding year that the mandatory program has not been triggered in nationally, the Secretary would determine whether the increase in hospital expenses nationally for the preceding year had exceeded the national voluntary percentage limit. In order to assure that reliable data is used to determine whether the rate of increase in total hospital expenditures had exceeded the national voluntary limit, individual hospitals would be measured against the national voluntary limit on the basis of expense data which is readily available from cost reports routinely submitted by hospitals for payment under the medicare program. The performance of any one hospital would not be crucial provided that, collectively, hospitals did not exceed the limit. However, in determining whether the 1979 national limit had been met, the Committee believes that hospitals should not be held accountable for that portion of their accounting year occurring before calendar year 1979. Accordingly, those months of an accounting period occurring in 1978 would be assigned an annual increase rate of 12.8 percent which was the actual national rate of increase in hospital expenses for that year. In succeeding years, the months of a hospital's accounting period which occur in the preceding calendar year would be assigned a rate of increase equal to the national voluntary percentage limit for that calendar year.

In determining whether the national voluntary percentage limit had been met, the Secretary would determine the dollar amount by which the expenses of each individual hospital differed from its assigned limit. If the sum by which all hospitals differed from the national limit were less than or equal to zero, the mandatory program would not be triggered nationally and all hospitals would be subject to a new voluntary limit for the next year. If the sum of the differences were greater than zero, the mandatory program would be triggered nationally.

The Committee believes that, in the event hospitals perform better than the national voluntary percentage limit, the limit for future years should reflect that fact, in order to preserve incentives for voluntary

cost containment efforts. Accordingly, the bill would provide that one-half of the dollar amount of "savings" (the dollar amount by which the sum of the dollar differences is less than zero) would be carried forward for use in offsetting any amount by which hospitals are over the national limit in succeeding years. Each year the amount of savings carried forward would be increased by a percentage equal to the national voluntary limit for that year.

Congressional review of national hospital performance.—Although the Committee concluded that a standby mandatory cost containment program is necessary in the event the increase in hospital expenses exceeds that national voluntary limit, the Committee is aware of the significant public policy implications of the triggering of mandatory controls. The Committee believes that a step of this importance, even though the mandatory program would be of limited duration, ought not to be taken without providing an opportunity for the Congress to examine the specific situation at the time the "trigger" is pulled to determine whether some unusual circumstances prevail or whether the facts at that moment might warrant congressional intervention in the otherwise automatic triggering process.

As a result the reported bill includes a provision under which the report of the Secretary that the voluntary limit has not been met can be disapproved if (a) before the end of 45 calendar days of continuous session after the date the report is submitted to the Congress, one House of the Congress adopts a resolution disapproving the report, and (b) before the end of the period, or if later the fifteenth day of continuous session after the date one House of Congress adopts a resolution disapproving such report, the other House has not adopted a resolution approving the report. If the above action takes place, the national voluntary hospital cost containment program will be deemed not to have failed for that year, and the mandatory program will not be put into effect. The Committee notes that it expects the Secretary to report to the Congress immediately upon his determination that the voluntary limit has or has not been met. If a report of the Secretary which indicates the voluntary limit has not been met in a given preceding year is disapproved under the procedures set forth, no further reports would be issued concerning that year.

State and individual hospital performance.—If the manatory program were triggered into effect the Secretary would then determine whether hospitals in each state had complied with the state voluntary program. This determination would be made, by summing the amounts by which individual hospitals in the State, when considered as a group differed from their voluntary percentage limits.

If the national and State voluntary limits are exceeded the bill provides the performance of each hospital would be compared to its limit and each hospital which meets its own voluntary limit would not be subject to mandatory controls.

As in the national voluntary program, one-half of any savings under the State voluntary program would be carried forward and used to offset, in future years, amounts by which hospitals in a State would otherwise be over their voluntary percentage limit. Individual hospitals would also receive the same carry forward. The accumulation of savings for both the State and individual hospital voluntary limits

would begin for accounting periods ending in 1979, for use at such future times as hospitals may be tested against voluntary State or individual limits.

Duration of National, State, and individual hospital voluntary periods.—The reported bill provides that the national voluntary period will begin with 1979 and end with the earlier of 1984 or the first year for which the Secretary has announced and reported to Congress that total expenses of hospitals in the United States for the year have exceeded the national voluntary limit for that year.

It provides that the voluntary period of a State will be considered to begin with 1979 and to end with the earlier of 1984 or the first year: (1) which is the last year of, or is any year after, the national voluntary period; and (2) for which the Secretary has announced that total expenses of hospitals in the State for the year have exceeded the State voluntary limit for that year.

Similarly the voluntary period of an individual hospital will be considered to begin with the hospitals accounting period ending in 1979 and to end with the hospital's accounting period ending in 1984, or, if earlier, the first accounting period:

(1) Which ends in the last year of, or in any year after, the voluntary period of the State in which the hospital is located; and

(2) For which the Secretary has informed the hospital that the hospital's expenses for the accounting period have exceeded the hospital's individual hospital voluntary percentage limit for that period.

Title II. Mandatory Hospital Cost Containment Program

PART A—ESTABLISHMENT OF MANDATORY PERCENTAGE LIMITS

Application of mandatory limts.—If there is failure to meet the several tests of compliance with voluntary percentage limits and if the Congress does not reject implementation of mandatory limits, a hospital would become subject to the mandatory limits for its first accounting period following the period in which it failed to stay below its individual voluntary percentage limit. The mandatory limits would apply to the hospital's inpatient revenues per admission, rather than to total expenses as during the voluntary period.

Separately calculated limits for each hospital would be imposed on average inpatient reimbursement payable by each cost payer per admission and on average inpatient charges per admission. (Cost payers are governmental programs such as medicare or private programs such as Blue Cross plans that reimburse hospitals on a basis related to the hospital's costs or on another basis other than inpatient charges.) Under the bill, cost payers are to limit their reimbursement to hospitals so as not to exceeed the average reimbursement payable per admission; hospitals are to limit their charges to other payers so as not to exceed the average inpatient charges per admission.

These revenue limits would allow, for any accounting period, a percentage increase over the hospital's base accounting period (the last period not subject to a mandatory limit) equal to the compounded sum of the percentage mandatory limits imposed for that accounting

period and previous accounting periods that were subject to mandatory limits. Compounding the limits allows hospitals full credit for success in staying below the limits in any year and avoids an incentive for the hospitals to raise their revenues up to the limit in order to receive the highest possible limit in subsequent accounting periods.

Since limits for a current accounting period would be calculated with reference to revenues in a base accounting period, it is necessary to reduce the figures for the base period to reflect the discontinuance of services that are no longer provided by the hospital. However, to encourage the discontinuation of inappropriate services, no reduction of the base accounting year figures would be made under the bill with respect to discontinued services found inappropriate by the state health planning and development agency (SHPDA) of the state in which the hospital is located.

The Committee recognizes the difficulty hospitals could face in staying within mandatory revenue limits if these limits did not take account of significant increases in the proportion of care provided by the hospital for which payment is not received. Accordingly, to recognize increases in charity care and bad debts, the bill provides that when the sum of a hospital's allowances for inpatient care provided to charity patients, and its uncollectible inpatient charges exceeds the previous year's sum, upon request by the hospital, compliance with the mandatory limits would be measured in terms of charges actually collectible, that is, by not counting as inpatient charges the allowances for care to charity patients and the uncollectible inpatient charges.

Calculation of mandatory percentage limit.—Because each hospital would have a separately calculated mandatory limit based on data some of which cannot finally be known until after the close of its accounting period, it is necessary to defer final determination of a hospital's limit until after the hospital has filed its medicare cost report for the accounting period. Under the reported bill, the Secretary would be required to compute and inform the hospital of its mandatory limit no later than 6 months after the end of its accounting period.

During its accounting period, however, a close approximation of its limit would be known to each hospital, based on the non-wage marketbasket estimates made by the Secretary and its knowledge of its own wage-related expenses and other factors in the calculation of the limit. Cost payers would make adjustments in their reimbursement to the hospital in accordance with the final limit, just as medicare today makes adjustments for overpayments and underpayments at the time of settlement of medicare cost reports. As indicated later, a hospital whose inpatient charges to other payers during the accounting period turned out to exceed the limit would put the excess into escrow to be drawn upon during a future period when its inpatient charges fell below the allowable limits.

In general, the mandatory limits would apply during a hospital's entire accounting period. However, since the cost containment limits do not apply after the end of 1984, the calculation for the portion of a hospital's accounting period falling in 1985 is modified to allow a percentage increase equal to the hospital's actual rate of increase in expenses in the accounting period over the expenses in the previous

accounting period. Also, a modified calculation is provided for the first accounting period in which a hospital is subject to mandatory limits. The regular calculation of mandatory limits applies only to the portion of the hospital's accounting period that falls in the calendar year in which the accounting period ends. For the preceding portion of the accounting period, the percentage increase allowed is based on the actually experienced percentage increase in the hospital's expenses in the preceding accounting period over its expenses in the second preceding accounting period.

Calculation of base percentage.—Under the mandatory program, wages for non-supervisory employees would be passed through in the calculation of limits, and inflation in the marketbasket of all other goods and services that hospitals purchase would be recognized, just as they would be during the voluntary period under title I of the bill.

Thus, the base percentage (which is subsequently modified by several adjustments) for a hospital's accounting period would be computed on the basis of the following:

(1) The percent increase in the wage marketbasket of the hospital for the accounting period, and

(2) The average national percent increase in the non-wage marketbasket for the accounting period (if available, area or state price data would be used). If it is greater, the calculation would use the estimated percent increase in the national non-wage marketbasket (announced quarterly in advance for 12-month periods) adjusted to reflect the relative size of the hospital's non-wage marketbasket. Thus, as during the voluntary period, hospitals would be guaranteed at a minimum a marketbasket increase estimated in advance even if actual inflation proved to be less than estimated. For accounting periods that begin before quarterly marketbasket estimates are first made, the minimum guaranteed marketbasket increase would be 6.5 percent.

Efficiency adjustment.—The reported bill includes, in the calculation of mandatory limits, an adjustment to recognize the relative efficiency of hospitals. Without such an adjustment, mandatory percentage increase limits would fail to reward management efficiency and would in effect penalize hospitals with lower costs than comparable hospitals.

To make such an adjustment, the Secretary would develop a system for grouping hospitals, based on such characteristics as patient case mix and metropolitan or nonmetropolitan setting. He would also develop a method to measure relative efficiency of hospitals in each group, using a group norm based on all or certain hospital expenses (adjusted for area wage differences). In determining individual hospital efficiency, the Secretary would take into account systemwide savings attributable to lower hospital inpatient utilization per capita in the area in which the hospital is located. Thus, if the measures of efficiency are based on per diem costs, hospitals in areas where admission rates and lengths of stay are low would not be penalized for the correspondingly higher intensity and cost per patient day.

A system for grouping hospitals and measuring their relative efficiency has already been developed, pursuant to section 1861(v) of the

Social Security Act, and is used in limiting medicare reimbursement to amounts that are necessary in the efficient delivery of needed health services. The Committee recognizes that this will essentially be the system used for the efficiency adjustment under the bill, but expects the Secretary to further develop and refine the method as rapidly as possible so that the relative efficiency of hospitals will be measured as accurately as feasible.

The Secretary would assign to each hospital a percentage bonus (or penalty) depending on the extent to which the hospital's adjusted expenses were less than (or exceeded) the group norm, as follows:

(1) Less than 90 percent of the group norm—a 1 percentage point bonus.

(2) Equal to or more than 90 percent of the group norm, but less than the group norm—a graduated bonus of from 1 percentage point to no percentage points.

(3) Equal to or more than the group norm, but not more than 110 percent of the group norm—no bonus or penalty.

(4) More than 110 percent of the group norm, but not more than 130 percent of the group norm—a graduated penalty of from no percentage points to 2 percentage points.

(5) More than 130 percent of the group—a 2 percentage point penalty.

The percentage bonus or penalty (if any) would be added to or subtracted from the hospital's base percentage for the accounting period.

Admissions adjustment.—In recognition that a hospital's average cost per admission may vary as the number of admissions increases or declines over time, the reported bill requires the Secretary to establish, by regulation, a method for the adjustment of the base percentage for the accounting period to reflect changes in the number of admissions between the current and a previous accounting period. The admissions adjustment is to be designed to take into account (1) the marginal costs associated with changes in admissions in one accounting period compared with a previous accounting period; (2) shifts in admissions caused by a hospital's entering into (or ending) contracts with health maintenance organizations; and (3) the impact of appropriate reductions in hospital utilization. A hospital that is dissatisfied with the application of this adjustment method and can demonstrate higher marginal costs than the method assumes in its case may apply to the Secretary for a change in its admission adjustment.

Adjustment for prior performance.—Concern has been expressed that individual hospitals, in anticipation of mandatory revenue controls, might allow their expenses to increase in order to put themselves in the best possible position under the mandatory program. Accordingly, the Secretary would assign to the hospital's first accounting period subject to a mandatory limit a percentage reduction equal to the amount by which hospital's percentage increase in expenses in the preceding accounting period exceeded its voluntary percentage limit for that period.

Because this percentage reduction, together with any efficiency penalty for the accounting period, may be unduly severe, the sum of the two would not be permitted to exceed one-half of the base percentage for the period. Any unused portion of this percentage reduction would

be carried forward to succeeding accounting periods of the hospital.

Exceptions.—The reported bill recognizes that the unique circumstances of some hospitals necessitates that provision be made for exceptions to the mandatory limits in order to provide relief where the application of the limits produce too severe a result. Rather than leaving the conditions for exceptions entirely to the discretion of the Secretary, the Committee's bill specifies a number of grounds on the basis of which, singly or in combination, a hospital may request an increase in its mandatory percentage limit. Regulations detailing guidelines for grounds for exception must include the following changes and circumstances:

(1) A substantial change in the hospital's capacity because of the closing of another health facility in the area of the hospital.

(2) A significant change in capacity or character of inpatient hospital services available in the hospital.

(3) A major renovation or replacement of physical plant.

(4) A significant shift among cost payers and other classes of payers.

(5) A significant increase in the coverage of inpatient hospital services by a cost payer.

(6) Higher expenses associated with the special needs and circumstances (including greater intensity of care) of the hospital because it is a regional tertiary care institution.

(7) The hospital is a sole community hospital which would otherwise be insolvent and the state health planning and development agency for the hospital has determined that the hospital should be maintained.

(8) Such other changes and circumstances as the Secretary finds warrant special consideration.

The exception relating to special needs and circumstances of regional tertiary care centers is not intended to apply to all large medical centers or to teaching hospitals generally, but to the relatively few tertiary care institutions whose operations include a wide range of specialized postgraduate medical training and a significant level of biomedical and other health-related research activities, and which function as regional referral centers as indicated by admission of significant number or a sizeable proportion (of at least 25 percent) of their patients from outside the health service area in which the hospital is located. This exception recognizes that medical centers with these characteristics render highly specialized and intensive care and may as a result experience higher increases in costs due to such factors as advancement in the level of the intensity of such care. It is the Committee's intention that institutions which function as national referral centers that serve patient communities extending beyond their immediate state and geographic regions, such as the Cleveland Clinic Foundation and the Mayo Clinic, would be included under this exception.

The listing of specific grounds for exceptions is not intended to foreclose other grounds. Therefore, the Committee has included in the above list "such other changes and circumstances as the Secretary finds warrant special consideration."

In applying the exceptions discussed above, the Secretary is to take into account, as appropriate, the financial solvency of the hospital and

the extent to which the hospital's actions conformed with health plans for the area in which it is located. However, in determining the financial solvency of the hospital, the Secretary would not be permitted to take into account amounts related to philanthropy, that is, any amounts related to certain designated or restricted gifts, grants, endowments and depreciation funds. The Committee has included this provision because it recognizes the valuable and important role that philanthropic gifts play in the hospital field and does not intend that hospital philanthropy be discouraged as a result of this legislation. Such amounts may be designated or restricted either by the donor or by the hospital's governing board. In the latter case, the Committee intends that the designation process not be misused in an effort to circumvent the intent of the bill.

A hospital's request for an exception is to be filed in such a manner and form as the Secretary prescribes. If a properly filed request has not been acted upon by the Secretary within 60 days of its filing, the request would be treated as granted. It is the Committee's intent that, to be considered properly filed, an exception must contain all the information needed by the Secretary to determine whether an exception should be granted and the amount of the exception. If such information is lacking, the Committee recognizes that the Secretary may be forced to deny the exception request on technical grounds. However, the Secretary would be expected to communicate promptly with the hospital so that it can provide the necessary information in a request that will be considered properly filed.

PART B—APPROVAL OF STATE MANDATORY PROGRAMS AND EXCEPTIONS FROM MANDATORY LIMITS

Approval of State mandatory programs.—A number of states have established mandatory cost containment programs or are in the process of establishing such programs. The Committee believes that where a state is willing to undertake such action, provision should be made for the state program to apply to hospitals within the state in lieu of the Federal mandatory program. The reported bill provides that in the case of a State which operates a mandatory cost containment program which was established by State statute prior to January 1, 1979, the State may apply to the Secretary for the approval of its program to operate in place of the Federal cost containment program. The Secretary is required to approve such programs. The Committee feels that those States which have demonstrated their commitment to control care costs by enacting mandatory cost containment legislation prior to January 1979 should be allowed to operate their programs unencumbered by new Federal requirements. Ten States have established such statutes: Colorado, Connecticut, Illinois, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Washington and Wisconsin. Colorado, which has recently passed legislation abolishing its cost containment statute, would not be eligible under this provision unless that action were reversed. It is the Committee's intent that this provision not apply if these States make changes of major significance in their programs such that the program will no longer contain health care costs.

Except for those mandatory State programs established by statute before January 1979, for a State program to be approved by the Secretary, it must either apply to (a) all hospitals covered under the Federal program and to all inpatient hospital revenues or expenses (other than medicare revenues, unless approved by the Secretary), or (b) at least 75 percent of all inpatient hospital revenues or expenses (including medicare revenues). In addition, the Secretary must receive satisfactory assurances as to the equitable treatment under the State program of hospital employees, patients, and all entities (including Federal and State programs) that pay hospitals for inpatient services. The State program is prohibited from treating directly or indirectly, as revenues of any hospital any of the hospital's amounts related to philanthropy, that is, any amounts attributable to certain designated or restricted gifts, grants, endowments and depreciation funds.

Approval of these State programs would also be contingent upon their meeting a test of effective performance. For any year, approval would be granted if, for hospital accounting periods ending in the preceding year, the State voluntary percentage limit was met or would have been met if it were increased by one percentage point. If this requirement is not met, for example because of the newness of the State program, the Secretary would nonetheless be required to approve the State program if he receives satisfactory assurances that hospitals in the State will meet the State voluntary percentage limit for the year in question.

The Secretary is not authorized to impose conditions for approval in addition to those specified in the Committee bill.

In establishing standards and reviewing applications for approval of state mandatory programs, the Secretary is required to consult with the National Commission on Hospital Cost Containment established under the bill.

The reported bill allows the Secretary to waive requirements for reimbursement under titles V, XVIII, and XIX of the Social Security Act for hospitals located in a State with a mandatory hospital cost containment program approved by the Secretary. A request of a State with an approved program shall be considered approved unless the Secretary acts within 90 days to deny it. The Committee understands that the request of the State must contain sufficient information by the Secretary to make his decision. If such information is lacking, the Secretary would be expected promptly to inform the State in order to avoid the necessity of denying the request on technical grounds. The reported bill requires the Secretary to waive these reimbursement requirements for States that have already been granted a waiver for demonstrated purposes if the percentage increase in revenues per admission for the previous year is no greater than the national voluntary percentage limit for that year.

Funding of State mandatory programs.—The Committee bill would authorize the Secretary to make grants to states to assist them in planning, establishing or operating state mandatory cost containment programs. Appropriations would be authorized for this purpose in the amount of $10 million for Fiscal Year 1980 and for such sums as may be necessary for the three succeeding fiscal years. The Secretary would determine the amount of any assistance to be provided, and it is the

Committee's intent that these grants be available with respect to both new and existing state programs and be provided, insofar as possible, for all states that can reasonably use them. The Committee believes that states should bear a significant share of the costs of planning, establishment and operation of their own programs, and has therefore specified that assistance under this Act may be provided for only up to 50 percent of the necessary costs involved.

Exemption of hospitals engaged in certain experiments or demonstrations.—Since the mandatory program is not intended as a permanent solution to the problem of rising hospital costs, experiments in the area of hospital reimbursement and cost containment should be continued. Accordingly, the Committee bill provides that a hospital may be exempt from the mandatory program if the Secretary determines that the exemption is necessary to facilitate experiments or demonstration programs conducted pursuant to specified provisions of law and such experiments or demonstrations are consistent with the purposes of the bill.

PART C—ENFORCEMENT

Civil penalty.—The Committee's bill would provide for the enforcement of the mandatory limits by providing that, if a hospital's cost-based revenues exceeded its mandatory limit, then the hospital would be subject to a civil penalty equal to 150 percent of the excess revenues. The Committee does not expect that the penalty would ever need to be imposed since the cost payers have no incentive to pay more than the hospital's mandatory limit, are able to control reimbursements closely on an interim basis during the year, and can adjust total annual reimbursement to the proper level at the time of final settlement each year.

The hospital would also be subject to a civil penalty if its revenues from charge payers exceeded its mandatory limits. Again, the Committee does not expect that the civil penalty will be applied since hospitals are able to set their charges so as to produce a specified amount of revenue and are experienced at monitoring revenues closely throughout the year. However, if a hospital were to miscalculate its charges in any year and collect revenues in excess of its limits, it could avoid the civil penalty by placing 100 percent of the excess for that year in an escrow account until the hospital has incurred a shortfall in allowable charge revenue equal to the amount of excess revenue.

The bill would require that before a penalty could be imposed, the Secertary give written notice and an opportunity for a hearing on the record with the right to be represented by counsel, to present witnesses, and to cross-examine. A person who is adversely affected by a determination of the Secretary under these provisions would be able to obtain judicial review of the determination.

Conformance by certain Federal and State programs.—Reimbursement under medicare could not be made in amounts that exceeded the applicable limits. For this purpose, in the case of hospitals subject to mandatory limits under the Federal program, the limits would be prescribed. In the case of hospitals in a state with an approved mandatory program, the limits would be those prescribed under the state program. Similarly, states would not be required to pay any amounts

in excess of the applicable limits (nor would Federal matching be available for such amounts) under medicaid or the Maternal and Child Health Program.

Title III. Commission, Administrative Provisions, and Definitions

PART A—NATIONAL COMMISSION ON HOSPITAL COST CONTAINMENT

National Commission.—Because of the significant implications of this legislation for hospitals, private insurers and the general public, the Committee believes it is essential to assure that the Secretary receives, on a direct and continuing basis, the advice and recommendations of knowledgeable representatives of the hospital and insurance industries, as well as consumers, on the implementation of the program. Thus, the bill establishes a National Comimssion on Hospital Cost Containment composed of fifteen members appointed by the Secretary, five of whom would be representatives of the Hospital industry, five of the insurance industry (including the Administrator, Health Care Financing Administration), and five other knowledgeable individuals. The Commission would be authorized to advise, consult with and make recommendations to the Secretary with respect to the implementation of the bill, proposed modifications to it, and any other matters affecting hospital expenses or revenues.

PART B—ADMINISTRATION PROVISIONS

Regulations and short accounting periods.—The Secretary would be provided general authority to issue regulations necessary to implement the bill. Such regulations are to be issued in a timely manner with appropriate opportunity for public review and comment. The Secretary is expected to promulgate in the Federal Register detailed information regarding any calculations to be made and the cirumstances to be taken into account in computing and adjusting the limits under the bill.

The Committee is aware that the Secretary will need to use estimates at some points in the course of performing the computations called for under the bill and that adjustments in available data and indices may be called for. It expects the Secretary to use the best information that is available on a timely basis, making such statistical adjustments as are necessary to accurately make the calculations required.

Hearings and appeals.—Under the bill, hospitals and payers dissatified with determinations made by the Secretary may obtain a hearing before the Provider Reimbursement Review Board of the amount in controversy in $10,000 or more and the hearing request is filed within 180 days after notice of the determination. Decisions of the Provider Reimbursement Review Board must be made within 60 days of the hearing by the Board and such decisions are subject to judicial review, consistent with existing procedures applying to the Board under section 1878 of the Social Security Act.

This provision is designed to provide review by an existing administrative review board which can promptly process appeals, is familiar with the issues in question, has rules and procedures which are well settled, and would not require the creation of another governmental entity. For purposes of appeals under the cost containment program,

the Board would be expanded by up to four additional members, at least one-half of whom must represent hospitals. In accordance with the present provisions of section 1878 of the Social Security Act, the Board would have the power to affirm, modify or reverse determinations of a fiscal intermediary or other entity acting on behalf of the Secretary relating to the calculation and application of mandatory limits, as well as adjustments and requests for exceptions with respect to these limits.

Consolidated treatment of hospitals with common ownership.—Under the reported bill, organizations that totally own or control, in a state, more than one hospital subject to the Federal cost containment program could have their revenue limits computed and applied in the aggregate for all such hospitals if the organization: (1) requests such treatment; (2) provides, on a timely basis, the data necessary to determine the limits; and (3) consolidates its hospitals employing the same accounting year.

This provision was included in the bill to permit commonly owned or controlled hospitals in a state (for example, municipal hospitals, hospitals owned or controlled by religious orders, or hospitals owned by proprietary organizations) the option of being treated on a consolidated basis for purposes of the application of mandatory revenue limits. The Committee recognizes that formal ownership of individual hospitals in a non-profit or religious chain is in many instances vested in individual hospitals instead of the chain. This practice has been established for a number of reasons. Some of these reasons include:

(*a*) Interpretations of charitable trust laws that require that ownership of the assets of a charitable organization be maintained in the same state in which the assets of the charitable organization exist; and

(*b*) Desires to limit legal liability to the individual hospital.

Non-profit chains, which are configured with ownership of assets at the individual hospital level, control these hospitals through a variety of means. For the purpose of this section, the chain or home office must have the right to review and reject or approve the budgets of the individual hospitals under its control.

In many instances, hospitals which are totally owned or controlled may find it administratively advantageous to have their revenue limits computed and applied in the aggregate rather than on an individual basis. Moreover, the Committee believes that this legislation should not discourage movement in the direction of mergers and consolidations wherever such actions contribute to cost containment. Although consolidated hospitals would not be eligible for exceptions, the Secretary would have the flexibility to make the necessary revenue limit calculations in a manner that takes into account the special aspects of a consolidated arrangement.

In order to make such consolidated treatment administratively feasible within the context of the program provided for in the bill, organizations wishing to consolidate any of their totally owned hospitals may only request such treatment for hospitals which are within a state and have the same medicare accounting year.

Improper changes in admissions practices.—Under the Committee's bill, a hospital would be prohibited from changing its admissions practices in a manner which result in a significant reduction in the

proportion of charity patients; a significant reduction in the proportion of patients for whom payment is (or is likely to be) less than the anticipated charges for or costs of such services; the refusal to admit patients who would be expected to require unusually prolonged or costly medical treatment for reasons other than those related to the appropriateness of the care available at the hospital; or the refusal to provide emergency services to any person who is in need of such services if the hospital provides for emergency care service.

The Secretary would be required to monitor, on a periodic basis, the extent of each hospital's compliance. In addition, the Secretary would investigate complaints from hospitals (or from other persons where he finds the volume and documentation of the complaints warrant investigation) that a hospital has improperly changed its admissions practices. Upon finding that the complaint is justified, the Secretary may (1) exclude the hospital from the medicare, medicaid, or maternal and child health programs or (2) reduce the amount of otherwise payable under the medicare program by $2,000 for each of the persons who were not appropriately admitted.

The bill further provides that any person may commence a civil action against any hospital which is alleged to be in violation of the prohibition against improper changes in admissions practices, but only if 180 days have passed from the date of the individual's complaint and neither the Secretary nor the Attorney General has commenced judicial proceedings or administrative action with respect to the alleged violation.

While the Committee believes there will be cases in which civil action may be warranted, it does not wish to encourage the proliferation of frivolous or nuisance suits. Therefore, the bill also provides that the court, in issuing any final order in any such action, or in issuing its decision in an action brought to review much an order, may award costs of suit and reasonable fees for attorneys if the cost determines that such an award is appropriate.

Medicare and medicaid bonus payments.—The Committee believes that one of the critical deficiencies in current cost reimbursement methods used by many third-party payers, including medicare and medicaid, is the absence of financial incentives for efficient performance. Considerable discussion has been focused in recent years on proposals to modify the medicare reimbursement method so as to provide incentive payments or bonuses to those hospitals which perform significantly more efficiently than other hospitals of comparable size, geographic setting, range of service and patient composition. Generally, these proposals envision the development of a system of grouping hospitals by particular characteristics, such as size and patient mix; the design of a method of measuring efficiency within each group that provides for setting a group norm; and the payment of bonuses to those institutions within the group whose costs of operation are well below the established group norm.

The Committee believes that although further development of such a sophisticated measurement and payment system is needed, a start should be made in this reimbursement approach and would be an immediately desirable complement to the cost containment program. Such bonus payments could, in the Committee's judgment, be built into the grouping and measuring system mandated elsewhere in the bill to enable the Secretary to provide for efficiency adjustments in

the calculation of a hospital's revenue limit. Thus, the bill includes provisions under which the Secretary would be authorized to provide a reimbursement bonus under medicare and medicaid to hospitals subject to the voluntary and mandatory cost containment programs that have kept their expenses below the average expenses of a group of similar hospitals. This bonus could be as large as one-quarter of the difference between the hospital's expenses and the group norm but in no case could it exceed 5 percent of the group norm or the amount which could be used for certain specified purposes (financing an outpatient deficit, retirement of long-term debt, or other approved uses in the public interest). The total amount of bonuses provided in any one fiscal year could not exceed $50 million. Any bonuses provided under this section would be additional to any other reimbursement otherwise payable by medicare and medicaid and would not be included as reimbursement for purposes of computing hospital revenue limits under the cost containment program.

In exercising his discretion under this section to provide for the payment of bonuses, the Secretary would be required to take into account the degree to which a hospital has been more efficient than other hospitals in its group and the existence of similar bonus payments under any state mandatory hospital cost containment program to which the hospital is subject.

Sunset provision.—The studies included in the reported bill reflect a general recognition of the fact that the cost containment program provided for in this legislation does not represent a permanent solution to the problem of rising health care costs. Such a long-range solution lies, at least in part, in the direction of basic changes in provider and consumer incentives for more efficient use of services, more responsive reimbursement methods, more comprehensive and effective health planning for the use and distribution of resources, and greater public cost consciousness—all of which will be the focus of the several studies and reports mandated by the bill. Consistent with the view that the cost containment program is intended only as a transitional response to the immediate crises created by escalating hospital costs, the Committee's bill includes a sunset provision which provides for the expiration of the limits imposed under the program on December 31, 1984. The mandatory limits, should they be required, would not apply to accounting periods of hospitals beginning in any year after that date.

PART C—DEFINITIONS

Definitions.—The reported bill contains definitions for use in carrying out the legislation. One of the most important definitions is that of "hospital". Since it defines those institutions which are covered by the bill.

Definition of "hospital".—The voluntary and mandatory limits do not apply to a hospital if it:

(*a*) Has met the conditions set forth in paragraphs (1) and (7) of section 1861(c) of the Social Security Act for less than 3 years;

(*b*) Had an average duration of stay of 30 days or more during the preceding three years;

(*c*) Derives 75 percent or more of its inpatient care revenues from one or more health maintenance organizations or other providers of ambulatory and inpatient health services on a prepaid basis;

(*d*) Has had during the preceding three years average annual admissions of 4,000 or less, and is located in a rural area (including an area that (i) is not an urbanized area as defined by the Bureau of the Census, and (ii) an area that is not part of an SMSA as defined by the Office of Management and Budget);

(*e*) Does not impose charges or accept payments for services provided to patients;

(*f*) Is a Federal hospital; or

(*g*) Is a psychiatric hospital.

Since it is the short-term, acute care hospitals that have been experiencing the greatest rate of increase in costs, the Committee believes it is appropriate to focus the cost containment program exclusively on these institutions rather than on long-term and psychiatric hospitals where costs are generally increasing at a significantly lower rate. New hospitals are exempt from the program because the high startup costs of new hospitals would not constitute an appropriate base on which to calculate allowable increases in revenues. Hospitals which receive a substantial portion of their revenues from HMO's and other prepaid providers are exempt so as not to introduce disincentives to the development of prepayment plans. Small rural hospitals are exempt because they address unique geographic and distributional problems of access to care and represent a very small part of total hospital revenues. Federal hospitals are not included because they generally do not collect revenues in a manner similar to community hospitals, and their budgets are directly controlled by the Congress.

VI. Program Oversight

The Committee's principal oversight activities with respect to this legislation have been conducted by the Subcommittee on Health and the Environment in connection with its consideration of the legislation, and by the Subcommittee on Oversight and Investigations in connection with its examination of the cost and quality issues of the health care delivery system. The findings of the Health and Environment Subcommittee are discussed in this report; the findings of the Oversight Subcommittee in Committee documents on the Quality of Surgical Care; Unnecessary Surgery, Skyrocketing Health Care Costs: The Role of Blue Shield; and Professional Standards Review Organizations.

VII. Inflationary Impact

As discussed elsewhere in this report, the Committee has assumed cumulative systemwide savings resulting from the enactment of this bill ranging from $19.9 billion (as estimated by the Congressional Budget Office) to $41.2 billion (as estimated by the Department of Health, Education and Welfare).

The Congressional Budget Office has estimated that, under their assumptions, the cumulative effect of $19.9 billion in savings would be a reduction in the Consumer Price Index of about .3 of a percentage point by 1984. Using CBO methodology, the impact on the rate of inflation of $41.2 billion in savings would be approximately .5 of a percentage point. Since the Committee has assumed that the savings will fall somewhere within the range of these estimates, it believes that the resulting impact on inflation in the general economy will be

reflected in a reduction in the CPI by 1984 in the range of .3 to .5 of a percentage point.

The Committee would stress that any action which can be taken at this time which results in a moderating effect on the rate of inflation is desirable. In attempting to ease inflationary pressures by reducing Federal expenditures on a program by program basis, it is often only the cumulative effect which is significant with respect to the rate of inflation in the general economy. The Committee believes, however, that a .3 to .5 percentage point reduction in the CPI is significant in itself and, considering all options available, is one of the major steps that can be taken to reduce the rate of inflation.

VIII. Agency Reports

Agency reports were requested on H.R. 2626 from the Department of Health, Education, and Welfare and from the Office of Management and Budget. The following report was received.

Executive Office of the President,
Office of Management and Budget,
Washington, D.C., July 27, 1979.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your request of March 21, 1979 for the views of this Office on H.R 2626, a bill "To establish voluntary limits on the annual increases in total hospital expenses, and to provide for mandatory limits on the annual increases in hospital inpatient revenues to the extent that the voluntary limits are not effective"

H.R. 2626 is identical to draft legislation submitted by the Secretary of Health, Education, and Welfare on March 6, 1979. The bill represents a major Administration initiative in fighting inflation and in controlling the sharp increases in hospital costs that have occurred over the past few years. If enacted, it would result in substantial savings annually to the Federal Government and the American taxpayer.

Recently the House Ways and Means Committee ordered H.R. 2626 reported with amendments. We believe it is vitally important that cost containment legislation be enacted during this session of Congress. As the President stated in his State of the Union message,

"There will be no clearer test of the commitment of this Congress to the anti-inflation fight, than legislation. . . . to hold down inflation in hospital care. . . . we must act now to protect all Americans from health care costs that are rising $1 million per hour, 24 hours a day—doubling every five years."

Accordingly, we urge your Committee to give prompt and favorable consideration to the enactment of legislation which would provide for an effective hospital cost containment program consistent with the approach proposed by the Department of Health, Education, and Welfare in H.R. 2626. Enactment of such legislation would be in accord with the program of the President.

Sincerely,

James M. Frey,
Assistant Director for Legislative Reference.

IX. Congressional Budget Office Estimate

Congressional Budget Office,
U.S. Congress,
Washington, D.C., October 9, 1979.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives,
Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 2626, the Hospital Cost Containment Act of 1979.

Should the Committee so desire, we would be pleased to provide further details on this estimate.

With best wishes,

Sincerely,

Alice M. Rivlin,
Director.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 2626.
2. Bill title: The Hospital Cost Containment Act of 1979.
3. Bill status: As ordered reported by the House Committee on Interstate and Commerce, September 26, 1979.
4. Bill purpose: The bill would specify guidelines for increases in hospital expenditures and impose revenue controls on hospitals that fail to keep within them. The national guideline would be at least 11.6 percent. The guidelines would be based on the inflation rate for hospital purchases, population growth, and an intensity-of-service factor. Revenue controls would take the form of caps on increases in inpatient revenues per admission. Several kinds of hospitals—including long-term, federal, and small, rural hospitals—would be exempt from the proposed program. Hospitals in states with hospital cost control plans enacted prior to 1979 would also be exempt. The bill authorizes funds for states that have their own hospital cost control programs. The bill also provides for bonus payments under the Medicare and Medicaid programs for efficient hospitals.
5. Cost estimate:

[By fiscal years; in billions of dollars]

	1980	1981	1982	1983	1984
Medicaid:					
Required budget authority	−0.05	−0.11	−0.18	−0.30	−0.44
Outlays	−.05	−.11	−.18	−.30	−.44
Medicare: Outlays	−.30	−.69	−1.21	−2.02	−3.05
State cost programs:					
Authorization level	.01	.01	.01	.01	.01
Estimated outlays	.01	.01	.01	.01	.01

The costs of this bill fall within budget subfunction 550.

The bill would reduce future federal liabilities through a change to an existing entitlement and therefore could permit subsequent appropriations action to reduce the budget authority for the Medicaid pro-

gram. The figures shown as "Required Budget Authority" represent that amount by which budget authority for the Medicaid program could be reduced, as a result of this bill, below the level needed under current law.

6. Basis of estimate: On the basis of latest CBO economic projections, the growth in hospital expenditures is expected to exceed the national guideline prescribed in the bill. For purposes of this estimate, it is assumed that hospitals will increase expenditures in 1979 by 13.8 percent, while the national guideline under the bill is estimated to be 12.9 percent.

A simulation model using five years of actual cost and related data for approximately 4,000 community hospitals was developed to estimate the number of hospitals failing the guidelines and subsequently coming under revenue controls. The average hospital not exempted would face a guideline of 13.0 percent in 1979 (see Table 1). About 55 percent of those hospitals would meet the guideline in 1979, either through their own performance or that of hospitals in their states. About 32 percent of the hospitals would meet the guidelines in both 1979 and 1980, and some 21 percent of the hospitals would meet the guideline in 1979, 1980, and 1981.

Hospitals with capital expenses that were approved under the planning process before enactment of the bill would deduct the interest and depreciation costs from their expenditures to compare their performances to their guidelines.

TABLE 1.—ESTIMATES OF AVERAGE PERCENTAGE GUIDELINES IN THE VOLUNTARY PROGRAM, AND PERCENTAGE OF COMMUNITY HOSPITALS MEETING THEM, 1979–81 [1]

Year of reporting period	Unadjusted guideline	Reporting period—adjusted guideline	Hospitals meeting guideline [2] (percent)
1979	12.4	13.0	55
1980	13.5	13.5	32
1981	11.9	11.9	21

[1] Average guidelines are weighted averages for all community hospitals not in States with mandatory hospital cost control programs and not exempted on the basis of characteristics.

[2] This is the percentage of those hospitals not already exempted by characteristics or by mandatory State program. For 1980 and 1981, this is the percentage meeting the guideline for 2 and 3 years respectively.

Less than half of all community hospitals would come under the revenue controls during the 1979–1984 period. Of all community hospitals, 22 percent would probably be under mandatory controls in 1980, and 37 percent of hospital revenues would be controlled (see Table 2). By 1984, 42 percent of hospitals and 61 percent of hospital revenues would be controlled.

TABLE 2.—ESTIMATES OF PERCENTAGE OF COMMUNITY HOSPITALS AND COMMUNITY HOSPITAL REVENUES UNDER FEDERAL MANDATORY CONTROLS, 1980–84 [1]

Year of reporting period	Percent of hospitals under Federal mandatory controls	Percent hospital revenues under Federal mandatory controls [2]
1980	22	37
1981	33	47
1982	38	54
1983	41	58
1984	42	61

[1] At community hospitals, including those in States with their own mandatory cost control programs and those exempted on the basis of characteristics.

[2] Percent of current policy revenues.

The revenue caps would be a combination of four factors: (1) the percentage increase in an index of prices that hospitals pay for goods and services, called a "market basket;" (2) downward adjustments for the amount a hospital exceeded the voluntary guideline in the previous year called the base period adjustment; (3) a bonus or penalty depending on how a hospital's costs compared to those of similar hospitals, called the efficiency adjustment; and (4) an increase or decrease to take into account the incremental costs of changes in admissions, called the admissions adjustment. The market basket index would be altered to reflect each hospital's actual wage increase for nonsupervisory personnel. For the first year that a hospital falls under revenue controls, its actual expenditure increase in the preceding year would be averaged with its cap for the year in which its accounting year ended.

The admissions adjustment would be left to the discretion of the Secretary of HEW. Under the formula now assumed by the HEW staff, and used for this estimate, allowed hospital revenues would equal "deemed" admissions times allowed revenues per admission. "Deemed" admissions would equal actual admissions if the increase in admissions over the previous year was less than 2 percent. If admissions increased by more than 2 percent, "deemed" admissions would equal 102 percent of base period admissions plus 75 percent of the admissions above 102 percent. If admissions declined from the year before, deemed admissions would equal prior year admissions minus 75 percent of the decline.[1]

The adjusted 1980 cap for those hospitals subject to it would average 11.5 percent (see Table 3). The large base period adjustment for 1980—3.9 percent—reflects the substantial degree by which those hospitals failing to meet the 1979 voluntary guidelines would exceed them. The efficiency adjustment would be about zero in the aggregate. The admissions adjustment would reduce the cap slightly in 1980 and have virtually no effect in 1981 through 1984. The reporting period adjustment, which combines the 1979 experience with the 1980 unadjusted cap, raises the 1980 cap to 11.5 percent.

TABLE 3.—ESTIMATES OF AVERAGE PERCENTAGE CAPS APPLIED TO HOSPITALS IN MANDATORY PROGRAM, 1980–82 [1]

Year of reporting period	Market basket	Base period adjustment	Admissions adjustment	Unadjusted cap [2]	Reporting period, adjusted cap
1980	12.3	−3.9	−0.2	8.1	11.5
1981	11.6	−2.4	.1	9.4	10.5
1982	10.1	−1.2	0	9.0	9.6

[1] Averages are for all hospitals subject to mandatory controls in that year and are weighted by allowed revenues in the previous reporting period.
[2] Components may not sum to total because of rounding. The efficiency adjustment is about zero in the aggregate.

[1] For example:

Base period admissions	Actual admissions	"Deemed" admissions
100	102	102
100	110	108 [(110–102) 0.75+102]
100	92	84 [100–(100–92) 0.75]

In addition, the bill provides for bonus payments under Medicare and Medicaid for efficient hospitals. Hospitals could receive extra reimbursements if their costs were lower than those of similar hospitals. Bonuses are estimated to cost $50 million a year (their limit), of which the federal portion would be about $45 million.

The controls would have a substantial impact on the rate of growth of hospital revenues. For all community hospitals, the average annual rate of increase for 1979–1984 would fall from 14.2 percent to 12.7 percent (see Table 4).

Federal outlays would be reduced by a total of approximately $8.4 billion over the 1980–1984 period (Table 5). The outlay reductions would be much larger in the out years than in 1980, when they would only be about $0.35 billion. This pattern results from the phasing-in of revenue controls, the reporting-period adjustment for a hospital's first year under revenue controls, and the fact that each year's cap would be applied to the previous year's allowed rather than actual revenue.

TABLE 4.—ESTIMATES OF THE EFFECT OF COST CONTAINMENT ON TOTAL COMMUNITY HOSPITAL REVENUES IN 1980–84

[Billions of dollars [1]]

Fiscal year	Revenues under current policy [2]		Revenues with cost containment		Savings: effect of cost containment
	Revenues	Annual increase (percent)	Revenues	Annual increase (percent)	
1978	59.1		59.1		
1979	67.3	13.8	67.3	13.8	
1980	77.4	15.1	76.5	13.7	−0.9
1981	88.2	14.0	86.2	12.7	−2.0
1982	100.5	13.9	97.1	12.6	−3.4
1983	114.5	13.9	109.0	12.3	−5.5
1984	130.5	14.0	122.4	12.3	−8.1
1980–84	511.1	14.2	491.2	12.7	−19.9

[1] Revenues are on a cash accounting basis. Both impatient and outpatient net revenues are included.
[2] This assumes continuation of the hospital industry's voluntary effort to control hospital costs.

Note: Components may not add to totals because of rounding.

TABLE 5.—ESTIMATES OF SAVINGS FROM THE HOSPITAL COST CONTAINMENT ACT OF 1979, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE, 1980–84

[Billions of dollars]

Fiscal year	Federal savings			Non-Federal savings	Total
	Medicare	Medicaid	Total		
1980 [1]	0.30	0.05	0.35	0.59	0.94
1981	.69	.11	.80	1.2	2.0
1982	1.2	.18	1.4	2.0	3.4
1983	2.0	.30	2.3	3.2	5.5
1984	3.0	.44	3.5	4.6	8.1
1980–84 [1]	7.3	1.1	8.4	11.6	19.9

[1] Includes savings from 1979.

Note: Components may not add to totals because of rounding.

Nonfederal payers would also experience substantial savings. These would be about $0.6 billion in 1980, growing to some $4.6 billion by 1984 for a total of approximately $11.6 billion over the five-year pe-

riod. Nonfederal payers would get a somewhat smaller proportion of the savings than their proportion of revenues because caps are applied separately to revenues from each cost payer and to those from charges to individuals. Since revenues per admission generated by Medicare increase more rapidly than overall revenues per admission (mostly because of the aging of the Medicare population), hospitals would have to reduce Medicare revenues to a larger degree than those from other payers.

Some of the savings experienced by nonfederal payers will, after a lag, increase federal revenues. Employer paid health insurance premiums are not taxable to either the employer or the employee. To the extent that premium reductions result in increased taxable compensation or profits, federal revenues will increase.[2] Premium payments by individuals entitle taxpayers to a deduction. Reduced premiums will increase revenues by reducing the size of these deductions. Revenue increases are projected as follows:

	Millions
1980	$0
1981	20
1982	40
1983	70
1984	110

It is more likely that the savings estimates are too high than too low. Factors that tend to make them too high include:

(1) Some revenue reductions would be accomplished by shifting services from an inpatient to an outpatient basis. A realistic estimate of savings must subtract the additional outpatient revenues from the reduction in inpatient revenues. Since there is little basis for an estimate of what proportion of revenue reductions would be derived from shifting services to an outpatient basis, this "netting out" was not performed.

(2) Hospitals in states having mandatory controls would be treated more leniently under the bill, providing an incentive for additional states to enact such legislation. To the extent that more states enact controls and thus, more hospials are treated leniently, net savings will be lower.

(3) Since the exceptions process was not specified in the bill, as introduced, it was impossible to allow for its effects in the calculations. The bill, as reported, specifies some of the conditions for which the Secretary of HEW may make exceptions. But since the Secretary's authority is the same in both versions of the bill, their effects on savings were not included in order to maintain consistency between estimates.

(4) Hospitals will inevitably find ways to reduce the impact of the controls by "gaming." While impossible to predict, such behavior would also reduce savings.

A factor that could cause the savings estimate to be too high or too low is changes in hospital behavior while under the guidelines. Some hospitals would reduce their expenditures in order to avoid mandatory controls. But others would be likely to increase expenditures.

For more details, see CBO, Controlling Rising Hospital Costs, September 1979.

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[2] Federal revenue increases will be limited by opportunities for employers to use premium savings for hospital coverage to increase other health benefits.

H.R. 2626 also authorizes $10 million in fiscal year 1980, and such sums as may be necessary in future years, for grants to states with their own hospital cost control programs to help cover administrative costs.

The HEW estimate that the administrative costs of the program will equal some $10 million a year appears reasonable. At this time, however, the budgetary impact is not certain.

Effective date: The bill would first apply to hospital accounting years ending in calendar year 1979. Savings could occur during hospital accounting years ending in calendar year 1980. Revenue controls could first be imposed January 1, 1980.

7. Estimate comparison: For H.R. 2626, as ordered reported by the House Committee on Interstate and Foreign Commerce, the Administration has estimated higher savings than CBO. HEW estimates total 1980–1984 savings as $41.2 billion, and federal savings at $16.7 billion. CBO estimates total 1980–1984 savings at $19.9 billion, and federal savings at $8.4 billion.

The major reason for the differences is different assumptions on how hospitals will react to passage of the legislation. For example, HEW assumes that hospitals will reduce their expenditure increases in fiscal year 1979 by an average of 1 percentage point. CBO makes no such assumption because: (1) in addition to incentives to decrease spending, the bill contains incentives for some hospitals to increase spending, once passage is assured; (2) most hospitals subject to the 1979 guideline began their accounting years before the announcement of the proposal; and (3) fiscal year 1979 has ended, and hospitals are unlikely to act prior to passage.

The second major reason for the difference is different projections of hospital spending absent the legislation. The most important difference appears to be the varying projections of service intensity increases. HEW projects greater service intensity increases than CBO. Since the bill would primarily affect service intensity growth, it follows that HEW would estimate higher savings.

8. Previous CBO estimate: The Congressional Budget Office has prepared an estimate of the savings from H.R. 2626 as reported by the House Committee on Ways and Means (July 30, 1979) and a revised estimate for that bill (September 17, 1979). The estimate of savings for H.R. 2626 as ordered reported by the Committee on Interstate and Foreign Commerce are higher, primarily because of the more restrictive sunset provision in the Ways and Means Committee bill.

9. Estimate prepared by: Paul Ginsburg, Scott Thompson, and Larry Wilson, HRCD.

10. Estimate approved by:

C. G. Nuckols,
(For James L. Blum, Assistant Director for Budget Analysis.)

IX. Section-by-Section Analysis of the Hospital Cost Containment Substitute

Section 1. Short Title

Section 1 establishes the short title of the bill as the "Hospital Cost Containment Act of 1979", and contains a Table of Contents.

52-219 O - 79 - 4

Title I—Voluntary Hospital Cost Containment Program

Part A—Establishment of Voluntary Percentage Limits

Section 101. National voluntary percentage limit

Section 101(a) requires the Secretary, before April of each year (beginning with 1980) to promulgate a national voluntary percentage limit for the preceding year. The limit would be the sum of the following four amounts:

(1) *Wages of nonsupervisory employees.*—The percent increase in national hospital wages for that preceding year.

(2) *Nonwage hospital marketbasket.*—The greater of:

(A) The actual percent increase in the national hospital non-wage marketbasket for that preceding year, or

(B) 6.5 percent for 1979, and for any other year, the estimated percent increase in the national hospital non-wage marketbasket for that preceding year as announced under section 101(b).

(3) *Population increase factor.*—The percent increase in the national population for that preceding year.

(4) *Net service intensity allowance.*—One percent.

Notwithstanding this formula, the national voluntary limit for 1979 could not be less than 11.6 percent.

Section 101(b) requires the Secretary, before the first calendar quarter beginning after enactment of the bill and before each succeeding calendar quarter before 1985, to estimate and announce the percent increase in the national non-wage marketbasket for the subsequent twelve-month period and the average fraction of expenses of hospitals in the United States attributable to goods and services in the non-wage marketbasket.

Section 102. Individual Hospital Voluntary Percentage Limits

Section 102(a) requires the Secretary to determine an individual hospital voluntary percentage limit for each accounting year of a hospital ending during the period beginning January 1, 1979, and ending December 30, 1984.

Section 102(b)(1) provides that for a hospital's accounting period that ended on December 31, 1979, these limits would be equal to the sum of the following four amounts:

(1) *Wages for nonsupervisory employees.*—The percent increase in the wage paid per nonsupervisory employee per hour of the hospital for the accounting period

(2) *Nonwage hospital marketbasket.*—The greater of the percent increase in the non-wage marketbasket of the hospital for the accounting period, or 6.5 percent

(3) *Population change factor.*—The percent change in population of the SMSA or county in which the hospital is located, or zero, whichever is greater.

(4) *Net service intensity allowance.*—One percent.

Section 102(b)(2) provides that for a hospital's accounting period that ended in 1979 before December 31, these limits would be equal to the sum of the following two amounts:

(1) *1978 factor.*—The percentage increase in the hospital's expenses in its accounting period that ended in 1978 over its ex-

penses in its preceding accounting period, multiplied by the fraction of the accounting period ending in 1979 that occurred in 1978.

(2) *1979 factor.*—The sum of the four amounts described in section 102(b)(1) for the accounting period, multiplied by the fraction of the accounting period that occurred in 1979.

Section 102(c) provides that for a hospital's accounting period that ends after 1979, these limits would be equal to the sum of the following four amounts:

(1) *Wages for nonsupervisory employees.*—The percent increase in the wages paid per nonsupervisory employee per hour for the accounting period.

(2) *Nonwage hospital marketbasket.*—The greater of—

(A) The actual increase in the nonwage marketbasket of the hospital for the accounting period, or

(B) 6.5 percent for an accounting period that began before the date of enactment of the bill; and for any other accounting period, the estimated percent increase in the national hospital non-wage marketbasket announced under section 101(b) for the twelve-month period beginning with the calendar quarter in which the accounting period began adjusted to reflect the hospital's fraction of expenses attributable to goods and services in the non-wage marketbasket.

(3) *Population change factor.*—The percent change in population of the SMSA or county in which the hospital is located, or zero, whichever is greater.

(4) *Net service intensity allowance.*—One percent.

Section 102(d) permits a hospital to elect to exclude certain expenses attributable to charity care and bad debts, a significant expansion of capacity or services approved by the state health planning agency, or a major expansion of a medical teaching program from the computation of its individual hospital expenses for purposes of its individual hospital voluntary percentage limit for all accounting periods of the hospital.

PART B—REVIEW OF PERFORMANCE DURING VOLUNTARY PERIOD

Section 111(a) requires the Secretary, before July 1, 1980, and before July 1 of each succeeding year, to determine whether the increase in hospital expenses in the United States for the preceding year exceeded the national voluntary limit. He is required to make that determination by first assigning to each hospital's accounting period that ended on December 31 of the preceding year the national voluntary percentage limit computed under section 101 for that preceding year. To each hospital's accounting period that ended before December 31 of that preceding year, he would assign the national voluntary percentage limit for that preceding year adjusted to conform to the hospital's accounting period. If the preceding year were 1979, the hospital would be assigned a limit equal to the sum of: (1) 12.8 percent multiplied by the fraction of the accounting period that occurred in 1978; and (2) the national voluntary percentage limit for 1979 multiplied by the fraction of the accounting period that occurred in 1979. If the preceding year

were 1980 or later, the hospital would be assigned a limit equal to the sum of:

(1) The national voluntary percentage limit for the second preceding year multiplied by the fraction of the accounting period that occurred in that second preceding year; and

(2) The national voluntary percentage limit for that preceding year multiplied by the fraction of the accounting period that occurred in that preceding year.

The Secretary would then determine the dollar amount by which the increase in the expenses of each hospital differed from its assigned limit and the sum of these dollar amounts. For 1979, if the sum is greater than zero, he is required to announce that the increase in hospital expenses in the United States for the preceding year exceeded the national voluntary limit for that year. If the sum is equal to or less than zero, he is required to announce that the increase did not exceed the national voluntary limit for the preceding year and he must credit, to a national carryforward account, an amount equal to one-half of the dollar amount of such savings.

Before determining whether the increase in hospital expenses exceeded the national voluntary limit for a year after 1979, the Secretary would apply any balance in the national carryforward account. If, after applying some or all of the balance, the sum is equal to zero, the Secretary is required to announce that the increase in hospital expenses in the United States did not exceed the national voluntary limit for the preceding year and he must debit, against the national carryforward account, the amount of the account applied. If, after applying all such amounts (and adjusting the carryforward account accordingly), the sum is still greater than zero, he must announce that the increase in hospital expenses in the United States for the preceding year exceeded the national voluntary limit for that year.

Section 111(b) requires the Secretary to report to each House of Congress on his determination of whether the national voluntary limit has been met, and include in the report details as to the basis for his determination.

Section 112. Congressional review of national hospital performance

Section 112(a) provides that a report submitted to Congress under section 111(b) shall be considered disapproved for purposes of section 115(a) if (A) before the end of the period of 45 calendar days of continuous session after the date the report is submitted to Congress, one House of the Congress adopts a resolution disapproving such report, and (B) before the end of such 45 day period, or, if later, the fifteenth day of continuous session after the date one House of Congress adopts (during such 45-day period) a resolution disapproving such report, the other House has not adopted a resolution approving such report.

Section 112(b) sets forth the process by which a House would adopt a resolution disapproving the report of the Secretary of Health, Education, and Welfare. Any introduced resolution shall immediately be referred to the appropriate committees. If the Committees have not reported it at the end of 30 calendar days it shall be in order to move to discharge the committees from further consideration of the resolution. Such a motion shall be highly privileged and limited to not more than one hour of debate. Debate on the resolution shall be limited to not more than five hours.

Section 112(c) provides that any interested party may institute such actions in the appropriate district court of the United States, including actions for declaratory judgment, as may be appropriate to construe the constitutionality of this section or section 115(a)(2). The district court immediately shall certify all questions of the constitutionality of such provisions to the United States court of appeals for the circuit involved, which shall hear the matter sitting en banc. Notwithstanding any other provisions of law, any decision on a matter certified under this provision shall be reviewable by appeal directly to the Supreme Court of the United States. Such appeal shall be brought not later than 20 days after the date of the decision of the court of appeals.

Section 113. State hospital performance

Section 113 requires the Secretary, before July 1, 1980, and before July 1 of any succeeding year before 1985, to determine whether the increase in hospital expenses in the State exceeded the State voluntary limit for the preceding year. He would make that determination by first determining the dollar amount by which the increase in the expenses of each hospital in the State in its accounting period ending in that preceding year exceeded the hospital's individual voluntary percentage limit (computed under section 102) for the hospital for the accounting period. The Secretary must exclude from such determination any hospital the voluntary period of which ended, under section 115(c)(2), in a year before such preceding year.

The Secretary would then determine the sum of these dollar amounts. For 1979, if the sum is greater than zero, he must announce that the increase in hospital expense in the State for the preceding year exceeded the State voluntary limit for that year. If, for 1979 or later years, the sum is equal to or less than zero, he must announce that the increase did not exceed the State voluntary limit for the preceding year and he must credit, to a State carryforward account for that State, an amount equal to one-half of the dollar amount of such savings.

Before determining whether the increase in hospital expenses in the State exceeded the State voluntary limit for a year after 1979, the Secretary would apply to it the State carryforward account. If the sum is then equal to zero, he must announce that the increase in hospital expenses in the State did not exceed the State voluntary limit and he must make appropriate adjustments to the balance of the State carryforward account to reflect the amount applied. If the sum is still greater than zero, he must announce that the increase in hospital expenses in the State for the preceding year exceeded the State voluntary limit for that year.

Section 114. Individual hospital performance

Section 114(a) requires the Secretary, when he computes an individual hospital voluntary percentage increase, to determine whether the percent increase in a hospital's expenses in its accounting period exceeded its individual hospital percentage limit for the period.

Section 114(b)(1) provides that for the accounting period ending in 1979, if there was an excess under section 114(a), the Secretary must inform the hospital that the increase in the hospital's expenses in the accounting period exceeded the hospital's voluntary percentage limit for that period. If there was no such excess, the Secretary must inform the hospital that the increase in the hospital's expenses did not exceed the hospital's individual voluntary percentage limit for the

period and he must credit, to a carryforward account for that hospital an amount equal to one-half of the dollar amount of such savings.

Section 114(b)(2) provides that for an accounting period ending in a year after 1979, if there was an excess under section 114(a), the Secretary must apply, against such excess and to the extent of such excess, the balance of the hospital's carryforward account. If, after applying some or all of such balance, there is no excess remaining, the Secretary must inform the hospital that the increase in the hospital's expenses did not exceed the hospital's individual voluntary percentage limit for the accounting period and he must debit, to the carryforward account for that hospital, the amount of the account applied. If, after applying all of such balance, there is still an excess, he must inform the hospital that the increase in the hospital's expenses in the accounting period exceeded the hospital's individual voluntary percentage limit for that period, and make appropriate adjustments to the carryforward account.

Section 115. Duration of National, State, and individual hospital voluntary periods

Section 115(a) provides that the national voluntary period will be considered to begin with 1979 and to end with the earlier of 1984 or the first year for which the Secreary has announced and reported to Congress that total expenses of hospitals in the United States for the year have exceeded the national voluntary limit for that year.

Section 115(b) provides that the voluntary period of a State will be considered to begin with 1979 and to end with the earlier of 1984 or the first year.

(1) Which is the last year of, or is any year after, the national voluntary period; and

(2) For which the Secretary has announced that total expenses of hospitals in the State for the year have exceeded the State voluntary limit for that year.

Section 115(c) provides that the voluntary period of an individual hospital will be considered to begin with the hospital's accounting period ending in 1979 and to end with the hospital's accounting period ending in 1984, or, if earlier, the first accounting period:

(1) Which ends in the last year of, or in any year after, the voluntary period of the State in which the hospital is located; and

(2) For which the Secretary has informed the hospital that the hospital's expenses for the accounting period have exceeded the hospital's individual hospital voluntary percentage limit for that period.

Section 115(d) specifies that, subject to the exemptions under the mandatory program, each hospital is subject to a mandatory limit for each accounting period (ending before December 31, 1985) which begins after the end of the voluntary period of the hospital.

Title II—Mandatory Hospital Cost Containment Program

Part A—Establishment of Mandatory Percentage Limits

Section 201. Application of mandatory limits

Section 201(a) provides that for any accounting period of a hospital subject to a mandatory limit, the average reimbursement per admis-

sion payable to the hospital by a cost payer and the average inpatient charges per admission of a hospital for the period may not exceed the average reimbursement per admission payable to the hospital by the cost payer, or the average inpatient charges per admission of the hospital, respectively, from the base accounting period of the hospital, by a percentage which is greater than the compounded sum of the percentage mandatory limits computed by the Secretary for that accounting period and previous accounting periods of the hospital.

Section 201(b)(1) requires that the average inpatient charges of the hospital (and the average reimbursement payable to the hospital by each cost payer) for the base accounting period be reduced by an amount equal to any inpatient charges (in the case of a cost payer, any such inpatient charges attributable to that cost payer) for the base accounting period for elements of inpatient hospitatl services that cease to be furnished in the accounting period subject to the mandatory limit, multiplied by the fraction of the accounting period during which those services are not furnished.

Section 201(b)(2) specifies that this reduction would not apply with respect to inpatient hospital services that have been found inappropriate by the State health planning and development agency (SHPDA) for the hospital.

Section 201(b)(3) provides that upon request by a hospital, the State health planning and development agency for the hospital must make a finding as to the appropriateness of specific health services after requesting the recommendations of the health systems agency for the hospital. This finding of a SHPDA would not be subject to further review.

Section 201(c)(1) specifies that a hospital may, in accordance with regulations prescribed by the Secretary, have its average inpatient charges per admission computed by considering as inpatient charges only those charges that are not uncollectible inpatient charges or allowances for charity care.

Section 201(c)(2) defines for purposes of section 201(c)(1) the term "uncollectible inpatient charges" and the term "allowances for inpatient care provided to charity patients."

Section 202. Calculation of mandatory percentage limit

Section 202 requires the Secretary, within six months after the last day of each hospital's accounting period subject to a mandatory limit, to compute and inform the hospital of a mandatory percentage limit for that accounting period. This mandatory perentage limit will be the percentage computed under sections 203 through 206 except that an adjustment would be made to account for the percentage increase in the hospital's expenses in the accounting period occurring prior to or after the period subject to the limit.

Section 203. Calculation of base percentage

Section 203 requires the Secretary to compute a base percentage for each hospital's accounting period subject to a mandatory limit. This base percentage for a hospital's accounting period would equal the sum of:

(1) The percent increase in the per hour nonsupervisory wages of the hospital for the accounting period, and

(2) The greater of:

(A) The percent increase in the non-wage marketbasket of the hospital for the accounting period, or

(B) 6.5 percent for an accounting period that begins before the first calendar quarter beginning after enactment of the bill; and for any other accounting period, the estimated percent increase in the national hospital non-wage marketbasket announced under section 101(b) for the twelve-month period beginning with the calendar quarter in which the accounting period began, adjusted to reflect the hospital's fraction of expenses attributable to goods and services in the non-wage marketbasket.

Section 204. Efficiency adjustment

Section 204 provides that, based on the method developed under section 314(a) for measuring a hospital's efficiency within a group of hospitals, the Secretary must assign to each hospital in a group, for each accounting period subject to a mandatory limit, a percentage bonus (or penalty) related to the extent to which the hospital's expenses (adjusted for area wage differentials) of the kind utilized in defining the group norm are less than (or exceed) the group norm, as follows:

(1) A bonus of one percentage point if the adjusted expenses are less than 90 percent of the group norm.

(2) A bonus which bears the same proportion to one percentage point as the proportion of (A) the percent difference between the group norm and the adjusted expenses, to (B) 10 percent, if the adjusted expenses exceed 90 percent of the group norm but do not exceed the group norm.

(3) No bonus or penalty if the adjusted expenses exceed the group norm but do not exceed 110 percent of the group norm.

(4) A penalty which bears the same proportion to two percentage points as the proportion of (A) the percentage difference between adjusted expenses and 110 percent of the group norm, to (B) 20 percent, if the adjusted expenses exceed 110 percent of the group norm but do not exceed 130 percent of the group norm.

(5) A penalty of two percentage points, if the adjusted expenses exceed 130 percent of the group norm.

The Secretary is required to add the amount of any bonus to (or subtract the amount of any penalty from) the base percentage computed for the hospital for the accounting period under section 203.

Section 205. Admissions adjustment

Section 205(a) requires the Secretary to establish, by regulation, a method for the adjustment of the base percentage (as adjusted under section 204) for the accounting period to reflect changes in number of admissions in the period compared to the number of admissions in a previous accounting period. In promulgating these regulations he is required to take into account:

(1) The marginal costs of hospitals associated with changes in admissions in one accounting period compared to a previous accounting period;

(2) Shifts in admissions caused by a hospital's entering into (or ending) contracts with health maintenance organizations; and

(3) The impact of appripriate reductions in hospital utilization.

Section 205(b) permits any hospital that is dissatisfied with an admissions adjustment to apply to the Secretary for an adjustment to the extent it can demonstrate that it has a higher marginal cost for changes in admissions in the accounting period than those assumed under such method.

Section 206. Adjustment for prior performance

Section 206(a) requires the Secretary to assign to the hospital's accounting period a percentage reduction in order to reflect the hospital's performance during its voluntary period. This percentage reduction, subject to the limitation under section 206(b), would be equal to:

(1) The percentage by which the percentage increase in the hospital's expenses in the preceding accounting period exceeded the hospital's voluntary percentage limit for that preceding accounting period in the case of the first accounting period of the hospital subject to a mandatory limit, and

(2) Any excess amount which has been carried forward under section 206(b) from a previous accounting period in the case of a succeeding accounting period.

Section 206(b) provides that, in the case of a hospital's accounting period for which the sum of the percentage penalty (if any) under section 204 and the percentage reduction otherwise assigned under section 206(a) would exceed one-half of the base percentage computed under section 203 (the increase in the wage and non-wage market basket) the amount of the percentage reduction assigned under section 206(a) for the period will be limited so that the sum of it and the percentage penalty for the period equals one-half of the base percentage for the period. Any excess amount is required to be carried forward to be assigned as a percentage reduction to the succeeding accounting periods of the hospital subject to a mandatory limit.

Section 206(c) requires the Secretary to subtract from the base percentage of a hospital (as adjusted under sections 204 and 205) the percentage reduction assigned to the period.

Section 207. Exceptions

Section 207(a) permits the Secretary, on the request of a hospital, to make further additions to the mandatory percentage limit to allow for higher reimbursement or inpatient charges per admission. Any such request must be filed, in such manner and form as the Secretary shall prescribe, with the appropriate agency or organization with which the Secretary as entered into an agreement under section 1816 of the Social Security Act.

Section 207(b) requires the Secretary to establish, by regulation, guidelines for the grounds for exceptions. Such grounds would include the following changes and circumstances which, as demonstrated by the hospital, result in higher reimbursement or inpatient charges per admission than otherwise permitted:

(1) A substantial change in the hospital's capacity because of the closing of another health facility in the area of the hospital.

(2) A significant change in capacity or character of inpatient hospital services available in the hospital.

(3) A major renovation or replacement of physical plant.

(4) A significant shift among cost payers and other classes of payers.

(5) A significant increase in the coverage of inpatient hospital services by a cost payer.

(6) Higher expenses associated with the special needs and circumstances (including greater intensity of care) of the hospital because it is a regional tertiary care institution.

(7) The hospital is a sole community hospital which would otherwise be insolvent and the State health planning and development agency has determined that it should be maintained.

(8) Such other changes and circumstances as the Secretary finds warrant special consideration.

A hospital may apply for an exception based upon a combination of these factors (no single factor of which would have been sufficient for a separate exception), if each of these factors can be demonstrated to have an appreciable and demonstrable effect on excess hospital expenses.

Section 207(c) requires the Secretary, in applying exceptions to individual hospitals, to take into account, as appropriate, the financial solvency of the hospital and the extent to which the hospital's actions conformed with health plans for the area in which it is located. In determining the financial solvency of a hospital for this purpose, the Secretary is prohibited from taking into account amounts related to philanthropy.

Section 207(d) provides that if a hospital files a request for an exception and the Secretary has not acted on the request within sixty days of its filing, the request for the exception would be treated as granted.

PART B.—APPROVAL OF STATE MANDATORY PROGRAMS AND EXEMPTIONS FROM MANDATORY LIMITS

Section 211. Approval of State mandatory programs

Section 211(a) permits the chief executive of any State to apply to the Secretary for the approval for a year of a State mandatory hospital cost containment program. The Secretary must approve the program for the year if the State mandatory hospital cost containment was established by statute before January 1, 1979; or if:

(1) He determines that the program will be applicable to all hospitals in the State and to all revenues or expenses for inpatient hospital services (other than revenues under title XVIII of the Social Security Act, unless approved by the Secretary) or to at least 75 percent of all revenues or expenses for inpatient hospital services (including revenues under title XVIII of the Social Security Act);

(2) He receives satisfactory assurances as to the equitable treatment under the program of all entitiess (including Federal and State programs) that pay hospitals for inpatient hospital services, of hospital employees, and of hospital patients;

(3) The program does not treat, directly or indirectly, as revenues of any hospital any of the hospital's amounts related to philanthropy; and

(4) He determines that for the previous year, if the State voluntary percentage limit (computed under section 102) were increased by one percentage point, he would determine that the sum of the dollar amounts for such previous year would be equal to or less than zero, or he receives satisfactory assurances that such sum of dollar amounts for the year will be equal to or less than zero.

Section 211(b) requires the Secretary, in establishing standards and reviewing applications for approval of State mandatory hospital cost containment programs under this section, to consult with the National Commission on Hospital Cost Containment.

Section 211(c)(1) exempts from a mandatory limit any accounting period of a hospital which ends in a year in which the State mandatory hospital cost containment program has been approved.

Section 211(c)(2) permits the Secretary to waive requirements for reimbursement under title XVIII of the Social Security Act for hospitals located in States with mandatory hospital cost containment programs approved under section 211, and requires such a waiver in certain circumstances. A request for a waiver shall be approved unless the Secretary within 90 days disapproves it.

Section 212. Funding of State mandatory programs

Section 212(a) authorizes the Secretary to make grants to States to assist them in planning, establishing, or operating State mandatory hospital cost containment programs.

Section 212(b) specifies that an application by a State for assistance must be in such form, submitted in such manner, and contain such information and assurances as the Secretary may require.

Section 212(c) authorizes the Secretary to provide assistance in amounts up to 50 percent of the necessary expenses involved with the planning, establishment, or operation of a State mandatory cost containment program, subject to appropriations.

Section 212(d) authorizes $10,000,000 to be appropriated for assistance under section 212 for the fiscal year ending September 30, 1980, and such sums as may be necessary for each of the three succeeding fiscal years.

Section 213. Exemption of hospitals engaged in certain experiments or demonstrations

Section 213 permits the Secretary to exempt hospitals from the application of a mandatory limit if he determines that the exemption is necessary to facilitate an experiment or demonstration, consistent with the purposes of the bill, which is under section 402 of the Social Security Amendments of 1967, section 222 of the Social Security Amendments of 1972, or section 1526 of the Public Health Service Act.

PART C—ENFORCEMENT

Section 221. Civil penalty

Section 221(a)(1) subjects the hospital to a civil penalty of 150 percent of the amount of any average reimbursement per admission payable by a cost payer that exceeds the mandatory limit for the hospital.

Section 221(a)(2) subjects the hospital to a civil penalty for 150 percent of the difference between (A) the amount of any average inpatient charges per admission that exceeds the mandatory limit, and (B) the amount deposited with respect to such excess in an approved escrow account, multiplied by the fraction if inpatient charges not attributable to cost payers. Escrow account balances remaining after the end of the last accounting period subject to a mandatory limit would be subject to section 221(a)(3).

Section 221(a)(3) subjects amounts withdrawn in a prescribed manner from an approved escrow account to a civil penalty of 150 percent of the amount so withdrawn. Escrow account balances remaining after the end of the hospital's last accounting year subject to a mandatory limit would be subject to a civil penalty equal to the amount remaining in such account.

Section 221(a)(4) permits a hospital which has average inpatient charges per admission in excess of its mandatory limit to establish, in a manner prescribed by the Secretary, an escrow account for the deposit of amounts with respect to excess inpatient charges, in order to avoid liability for a civil penalty. If the Secretary certifies that the average inpatient charges per admission of a hospital fall below the mandatory limit for an accounting period, the hospital may withdraw from an escrow account previously established an amount equal to the product of (A) the amount by which the inpatient charges of the hospital for that accounting period could be increased without causing them to exceed the mandatory limit, and (B) the fraction of those charges not attributable to cost payers.

Section 221(b) provides that the civil penalties provided under section 221(a) would be assessed by the Secretary only after the hospital has been provided written notice and opportunity for a hearing on the record at which the hospital would be entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the hospital.

Section 221(c)(1) permits a hospital adversely affected by an assessment by the Secretary of the civil penalty to obtain a review in the United States court of appeals for the circuit in which the hospital is located, specifies procedural requirements and the jurisdiction of the court, and empowers the court to affirm, modify, remand, or set aside, in whole or in part, the assessment of the Secretary.

Section 221(c)(2) provides that no objection that has not been urged before the Secretary would be considered by the court, unless the failure or neglect to urge such objection is excused because of extraordinary circumstances.

Section 221(c)(3) provides that the findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, would be conclusive.

Section 221(c)(4) permits the court to order additional evidence to be taken before the Secretary and made a part of the record, provided that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary. The Secretary is permitted to modify his findings of facts, or make new findings, by reason of additional evidence. Upon the filing of the record, the jurisdiction of the court would be exclu-

sive and its judgment and decree would be final, except that it would be subject to review by the Supreme Court of the United States.

Section 221(d)(2) specifies that a determination by the Secretary to assess a penalty under section 221 will be final upon the expiration of a 60-day period unless the hospital against which the penalty has been assessed files for a review of such assessment.

Section 221(e)(1) requires each private cost payer to report to the Secretary (or an agency or organization designated by the Secretary) data on charges, total reimbursement payable, and number or admissions and related private reimbursement data for each hospital for which it makes payments based on costs of providing services and for which a mandatory limit applies, and provides the Secretary access to books and records as necessary to verify such reports.

Section 221(e)(1) requires each private cost payer to report to the United States district court or to any court of general jurisdiction in any State in which the cost payer operates to enjoin a private cost payer's failure to meet the requirements of section 221(e)(1).

Section 222. Conformance by certain Federal and State programs

Section 222 specifies that reimbursement for inpatient hospital services under the programs established by titles V, XVIII, or XIX of the Social Security Act, would not be payable to a hospital for an accounting period:

(1) Which is subject to a mandatory limit to the extent that the reimbursement exceeds such limit; or

(2) Which is exempted from such a limit because the hospital is located in a State with an approved mandatory hospital cost containment program, to the extent that the reimbursement exceeds the limit prescribed under such program.

Title III—Studies, Administrative Provisions, and Definitions

PART A—STUDIES AND REPORTS

Section 301. National Commission on Hospital Cost Containment

Section 301(a) requires the Secretary to establish a National Commission on Hospital Cost Containment.

Section 301(b) specifies that the Commission must consist of fifteen members appointed by the Secretary. Of those members, five must be individuals representative of hospitals; five must be individuals representative of organizations that reimburse hospitals (of whom one must be the Administrator of the Health Care Financing Administration); and five must be individuals who are not representative of either hospitals or of organizations that reimburse hospitals.

Section 301(c) establishes the term of appointment at three years.

Section 301(d) provides that the Secretary appoint one of the members as Chairman.

Section 301(e) specifies that eight members of the Commission constitute a quorum.

Section 301(f) requires the Commission to advise, consult with, and make recommendations to the Secretary with respect to the implementation of the bill, proposed modifications to the provisions of the

bill, and any other matters that may affect hospital expenses or revenues.

Section 301(h) permits the Commission to hire staff and consultants necessary to carry out its functions.

Section 301(i) specifies that the Federal Advisory Committee Act would not apply to the Commission.

PART B—ADMINISTRATIVE PROVISIONS

Section 311. Regulations and short accounting periods

Section 311 permits the Secretary to prescribe regulations to implement the provisions of the bill, and to determine or estimate any amounts or limits specified in the bill to make appropriate adjustments in its application with respect to short accounting periods.

Section 312. Hearings and appeals

Section 312 provides that any hospital or payer dissatisfied with a determination made on behalf of the Secretary may obtain a hearing before the Provider Reimbursement Review Board if the amount in controversy is $10,000 or more and the request for such hearing is filed within 180 days, and requires the Board to render its decisions not later than 60 days after the last day of the hearing.

Section 313. Consolidated treatment of certain hospitals with common ownership

Section 313 provides that an organization that totally owns or controls in a State two or more hospitals the accounting periods of which are subject to mandatory limits established under part A of title II, which have the same accounting period, and which were totally owned or controlled by the organization as of the date of the enactment of this Act may have the limits under such part on average reimbursement per admission and on the average inpatient charges per admission (and any civil penalty thereon under section 221) computed and applied in the aggregate for all such hospitals with the same accounting period in the State, rather than on each such hospital.

Section 314. Improper changes in admissions practices

Section 314(a) prohibits a hospital from changing its admission practices in a manner which results ~~in~~:

(1) A significant reduction in the proportion of its patients who have no third-party coverage and who are unable to pay for inpatient services provided by the hospital.

(2) A significant reduction in the proportion of persons admitted to the hospital for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such services.

(3) The refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital, or

(4) The refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services.

Section 314(b) requires the Secretary to monitor, on a periodic basis, the extent of each hospital's compliance with section 315(a).

Section 314(c)(1) provides that, upon written complaint by a hospital or such volume of written complaints or such reasonable documentation from any person (as the Secretary finds sufficient) that a hospital has violated section 315(a), the Secretary must investigate the complaint and, if it is justified, he may:

(1) Exclude the hospital from participation in any or all of the programs established by title V, XVIII, or XIX of the Social Security Act, or

(2) Reduce the total amounts otherwise reimbursable to the hospital under title XVIII of the Social Security Act in an amount equal to $2,000 for each of the number of persons who were not admitted as patients because of the change, or both

Section 314(c)(2) permits the Secretary to take any other action authorized by law (including an action to enjoin such a violation brought by the Attorney General upon request of the Secretary) which will restrain or compensate for a violation of Section 314(a).

Section 314(d) permits an appropriate civil action to restrain an alleged violation of section 315(a) to be brought by a person other than the Secretary, but only if:

(1) 180 days have passed from the date a complaint with respect to that alleged violation has been filed by the person with the Secretary, and

(2) Neither the Secretary nor the Attorney General has commenced and is diligently pursuing judicial proceedings or administrative action with respect to the alleged violation.

Section 314(e) specifies that nothing in section 315 restricts any right which any person (or class of persons) may have under any other statute or at common law to seek enforcement of the bill or to seek any other relief.

Section 315. Determination of relative efficiency of hospitals and medicare and medicaid bonuses for efficiency

Section 315(a) requires the Secretary to develop (and to revise from time to time), by regulation, a system of grouping hospitals by appropriate characteristics, such as patient case mix and metropolitan nonmetropolitan setting. He is required to establish, by regulation, a method of measuring efficiecy within each group that provides for setting a group norm, defined in terms of all or certain hospital expenses (adjusted for area wage differentials). In determining individual hospital efficiency under the method, the Secretary is permitted to take into account systemwide savings attributable to lower hospital inpatient utilization per capita in the area in which the hospital is located. If the hospital provides care to a greater percentage of patients 65 years of age or older than the average percentage for its group, the Secretary is required to adjust the amount of the hospital's expenses to take into consideration the higher average costs associated with care for patients 65 or older to the extent of such excess percentage.

Section 315(b) permits the Secretary to provide for a bonus in the amount otherwise reimbursable to a hospital under title XVIII or

under a State plan approved under title XIX of the Social Security Act. Such a bonus may not exceed the lesser of:

(1) One-quarter of the total amount of the savings under such title or plan of the hospital below the norm, or

(2) Five percent of the amount of the expenses for the group norm per unit measurement multiplied by the number of units of measurement associated with the hospital's performance.

It provides that the bonus may not exceed amounts used to finance the hospital's outpatient deficit, reduce long-term debt, or fund other uses determined to be in the public interest, and clarifies that the bonus would be additional to any other reimbursement and would not be include for purposes of computing the mandatory limit. It requires bonuses to be paid from the Federal Hospital Insurance Trust Fund and under a State plan approved unter title XIX of such Act. Bonuses in any fiscal year would be limited to no more than $50,000,000 in the aggregate.

Section 316. Sunset provision

Section 316(a) specifies that (except as otherwise provided in the bill) the provisions of the bill relating to:

(1) The national voluntary percentage limit will not apply to years after 1983;

(2) Individual voluntary percentage limits will not apply to accounting periods of hospitals beginning in any year after 1984;

(3) Federal mandatory limits on individual hospitals will not apply to accounting periods of hospitals beginning in any year after 1984; and

(4) Medicare and Medicaid bonuses under section 315(b), will apply only with respect to accounting periods ending after December 31, 1979, and before January 1, 1985.

Section 316(b) specifies that section 315 will not apply to changes in admissions practices occurring after December 31, 1984, but that the exclusion or reduction provided in section 314(c)(1) with respect to improper changes in admission practices occurring before January 1, 1984, would not be precluded.

Section 316(c) specifies that the National Commission on Hospital Cost Containment must be established not earlier than October 1 of the year in which the bill is enacted and must be terminated on March 1, 1985.

PART C—DEFINITIONS

Section 321. General definitions

Section 321 defines for purposes of the bill a number of general terms.

The term "hospital" means an institution that satisfies paragraphs (1) and (7) of section 1861(e) of the Social Security Act and has satisfied those conditions during the preceding 36 months, but does not include any such institution if it:

(1) Had an average duration of stay of 30 days or more during the preceding 36 months;

(2) Derived 75 percent or more of its inpatient care revenues from one or more health maintenance organizations or other pre-

paid providers of ambulatory and inpatient health services during the preceding 12 months;

(3) Is located in a rural area (which includes an area that is either outside an urban area, as defined by the Bureau of the Census or outside a Standard Metropolitan Statistical Area, as determined by the Office of Management and Budget) and had average annual admissions of 4,000 or less during the preceding 36 months;

(4) Does not impose charges or accept payments for services provided to patients;

(5) Is a psychiatric hospital;

(6) Is a Federal institution.

Section 322. Definitions relating to charges, expenses, and reimbursement

Section 322 defines terms relating to charges, expenses, and reimbursement.

Section 323. Definitions relating to marketbasket increases

Section 323 defines for purposes of the bill a number of terms relating to marketbasket increases.

Section 324. Definitions relating to population changes

Section 324 defines, for purposes of the bill, a number of terms relating to population changes.

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XI. MINORITY AND SEPARATE VIEWS

H.R. 2626—Hospital Cost Containment Act of 1979

I. OVERVIEW

During the 95th Congress the Commerce Committee spent over six weeks deliberating the question of Hospital Cost Containment and ultimately rejected imposing mandatory price controls on the nation's hospitals. This year the Subcommittee on Health and the Environment tabled H.R. 2626 by a two-to-one margin. Nevertheless, the House is now faced with a decision on a bill which contains all of the objectionable features of the legislation which the Subcommittee saw fit to reject.

We cannot support H.R. 2626, as amended, and would urge our colleagues to join us in rejecting this misguided and improperly focused response to the rising costs of health care in this country. Certainly we recognize that resources for health care, as for other vital services, are not unlimited, and we have urged the initiation of a thoughtful exploration of the fundamental causes of rising health care costs. Unfortunately, the inflated rhetoric surrounding the Hospital Cost Containment Act since its introduction in 1977 has obscured and retarded any real effort to discern, or to modify, the economic forces leading to increases in expenditures for health care. As described more fully below, the Administration instead has presented legislation which will seriously interfere with the ability of many hospitals to provide the quality medical care which the citizens of this country have every right to expect. Moreover, we would submit that this legislation is not only unlikely to achieve the inflated goals which proponents have claimed on its behalf, but will undoubtedly impose a bureaucratic nightmare on an already over-regulated industry.

The bill is infected by at least four cardinal errors, namely: (1) it treats the effects of rising costs rather than the root causes; (2) its arbitrary controls affect needed care instead of only that which is deemed to be unneeded; (3) it fails to give sufficient recognition to the success of the ongoing voluntary efforts to contain costs; and (4) it will not curb the increasing expenditures for hosiptal services.

II. FALLACY NO. 1: TREATING THE EFFECTS INSTEAD OF THE CAUSES

Most of the recent literature on increases in expenditures for hospital care has revolved around a common theme—increases in these expenditures are fueled by the system of financial incentives created by the present structure of health insurance and third-party reimbursement of providers. Notwithstanding this apparent agreement on the causes of increases in expenditures, the Administration bill, as well as the Committee's, share the defect of ignoring the need for altering the signals and incentives inherent in the existing system. Alain C. Entho-

ven, a distinguished professor at Stanford University, has put it this way:

> Overall controls on hospital spending face similar prospects: circumvention, unbundling, exceptions. The Administration proposal has already been emasculated by the wage pass-through, despite the fact that hospital workers now earn more than their counterparts doing similar jobs in other sectors. But even if it were ultimately successful at controlling total hospital spending at the stated growth rate, there would be no force in the system to assure efficiency or equity in the allocation or production of services. At best, we would have frozen the hospital industry in its present wasteful and inequitable pattern.[1]

These incentives leading to growing intensity of hospital services, especially increasing numbers of personnel and growing use of ever more sophisticated equipment, have not been put in place by accident. Through the passage of Medicare and Medicaid, the Hill-Burton program, Regional Medical Programs, and a host of other categorical health programs, as well as through the design and application of the tax code, we have demonstrated time and time again a desire to provide the finest care available to every American, regardless of cost.

This perfectly understandable goal had led the intensity of hospital services to grow at about five percent per year from 1969 to 1978. To a large extent, this increase has been due to increased frequency of common procedures, such as x-rays and laboratory tests. For example, charges for clinical lab tests amount to about 8 percent of total charges per stay. In 1971 these charges were about $52 per stay on the average. By 1976, they had risen to nearly $99 per stay, or by about 90 percent. Yet fully four-fifths of this increase was due not to inefficiency of the hospital but rather to increased volume of lab tests per admission (15.6 in 1971 to 25.0 in 1976). Had the volume or intensity of lab tests provided remained constant, the increase in charges per admission would have only increased 18 percent instead of 90 percent.

In addition to the increased intensity of common procedures, there has been major growth over the past decade in the development and provision of specialized treatment. Such specialized treatments include organ transplants, open heart surgery, intensive care and coronary care, renal dialysis, microsurgery, neonatal intensive care, burn units, hip replacements and heart pacemakers.

The facilities to provide these specialized treatments are disproportionately expensive to build, equip and operate. Had they not been built, total hospital expenditures might have been greatly reduced, but who among those who claim to support this bill seriously would suggest that they should not have been built—and the people treated for cancer, burn injuries, trauma, or renal disease deprived of their services? Yet, H.R. 2626 certainly would impose severe limits that, in many instances, would lead to rationing these services—and would do so in a manner that does not relate to need or other, non-financial considerations. Thus far, the Administration and other supporters of

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[1] Alain C. Enthoven, "Consumer Choice Health Plan: An Approach to National Health Insurance Based on Regulated Competition in the Private Sector," unpublsihed report to Joseph A. Califano, Secretary of the Department of Health, Education, and Welfare, September 22, 1977, p. 3.

the bill simply have not faced up to the serious legal, economic, and moral issues that such action contemplates. When people are in need of hospital care they expect to and should be able to receive the benefits of such advances in knowledge and technology.

By the same token, those who lament that hospital or health care costs generally are consuming a greater portion of GNP than previously are not persuasive. There is nothing magical about figures like 8 percent or 9 percent of GNP. What is important is receiving value for money spent; and most patients are willing to spend more money for new and improved diagnostic and therapeutic care that may relieve suffering or even save the lives of themselves and their families. Moreover, it has been established that when hospital expenses are adjusted for admissions growth and patient mix change (due, among other reasons, to growth and aging of the population), for improvement in the quality of care, and when viewed over a meaningful period of time, the rate of hospital price increase is far lower than has been suggested by HEW.

Nevertheless, the Administration proposed, and the Committee specifically agreed to impose, a one percent limit on annual increases in "net intensity," under the "voluntary" revenue limits and *no* allowable increase for intensity under the mandatory limits. These limits are proposed notwithstanding the historical five percent annual increase in intensity, and with no attention paid to the forces which cause these increases. Unfortunately, as was amply demonstrated by the failure of the Economic Stabilization Program's price controls to dampen these increases, there is very little reason to believe that the "flood of cost escalation can be dammed by a system of revenue or expense controls that leaves unchanged both the financial incentives and the values and appetites from which they derive." [2]

HEW and the Administration have simply refused to recognize the central issue surrounding rising expenditures for hospital care. This key policy issue has been stated best by Professors William B. Schwartz of the Tufts University School of Medicine and Paul L. Joskow of the Massachusetts Institute of Technology:

> So far, public discussion of health-care costs has taken for granted that the principal culprit is money spent for no return whatever. We doubt, after a rather close look at the available evidence, whether pure production inefficiency and care that yields no medical benefit account for more than a small fraction of the rising cost of health care. The largest proportion of expenditures, we believe, will prove to be of the type that buys at least some medical benefits. The key question is to what extent such care is purchased at excessive cost and to what extent we are prepared to forgo other investments to provide such care.[3]

In other words, we need to begin a specific and detailed discussion on what health services we wish to buy, and what portion of our resources we wish to commit to these purposes, something which cannot be achieved through arbitrary price controls.

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[2] Jack A. Meyer. "Health Care Cost Increases," American Enterprise Institute for Public Policy Research. Washington, D.C., 1979. p. 29.

[3] William S. Schwartz and Paul L. Joskow, "Medical Efficiency versus Economic Efficiency: A Conflict in Values," *New England Journal of Medicine,* vol. 299, No. 26 (December 28, 1978), pp. 1462–64.

III. FALLACY NO. 2: ARBITRARY CONTROLS WILL AFFECT ONLY "UNNEEDED CARE"

The Administration's basic justification for this legislation is that hospitals are inherently wasteful, and that the great majority of intensity increases over the past decade have been composed of unnecessary expenditures for superfluous gadgetry, redundant or dangerous equipment, and unneeded beds. In this regard, HEW argues that the elimination of certain glaring "wastes" in the hospital system will be the result of the passage of their proposal. However, an examination of the largest assumed "savings," through improvements in efficiency, a $4 billion saving through closure of 130,000 hopital beds which HEW estimates to be unneeded, once again underscores the illogic in the thinking behind this bill. The Congress has recently approved a three-year extension of the National Health Planning and Resources Development Act of 1974, including within which was a new program to carefully identify, and to voluntarily close, unneeded hospital capacity. In contrast, there is nothing in this legislation about identifying closing capacity which is truly unneeded. Instead, one must assume that the Administration intends that the bill's price controls will force the hospitals in question to close beds due to insufficient revenue. Such a process clearly will be indiscriminate in the extreme, and may, therefore, force needed hospital beds to close. For example, the hospitals most likely to be penalized through the application of indiscriminate percentage revenue caps will be the public hospitals which are already poorly funded and upon which many of the poor and disadvantaged depend for their care.

It should be kept in mind that even if one accepts completely HEW's arguments that there exists a large amount of excess services and capacity in the hospital industry, that excess is maldistributed, as are all medical services in this country. The constraints on revenue contained in this legislation might begin to shrink this excess, but there is absolutely no guarantee that these price controls will have more effect on unneeded services than on needed ones. The Committee intends to impose the same basic limit—one percent—on the intensity increases allowed hospitals in order to meet voluntary controls, and a zero percent limit on those who fail to meet the limit, without regard to the need of a particular community for hospital services. Some hospitals must continue to provide the esoteric services which are needed by few patients. The Administration provides no answer to the dilemma faced by the few patients in need of those expensive services if their hospital decides to cut that service. Instead this bill will insure that all hospitals will be underfunded rather than insuring sufficient funding for those institutions and services needed by the community.

Besides being illogical, a flat cap on intensity increases is extremely inequitable, as well. Development of health care facilities has not progressed evenly throughout the nation, and rural areas of the country in receiving the benefits of modern health care technology. Since this legislation's price controls have no relationship to the need of a community for new or different services, this bill will freeze in place the existing inequitable distribution of health care services. In other words, the Administration is proposing to deny to a large

segment of the American population, particularly those living in rural portions of the South and West, the benefits of modern health care which their fellow citizens in other parts of the nation already enjoy. The point is, how can you cut out "fat" when it isn't there in the first place?

The perverse illogic of arbitrary price controls can be demonstrated in another way because these controls will reward hospitals which have been inefficient in the past, or which have a number of services or facilities which are underused, and will penalize hospitals which have ben frugal and efficient, or which have stopped providing unneeded or underused services. This is because the limits on the allowable rate of increase under the voluntary program are a percentage of what the hospitals' expenses were in the base year. Thus hospitals which have been cost-conscious or have deferred high-cost improvements will have a lower limit than those which have spent more in the past. One thing is clear: a flat percentage of a "fat" budget provides higher revenue than a flat percentage of a "lean" budget.

IV. FALLACY NO. 3: VOLUNTARY EFFORTS TO CONTROL COSTS WON'T WORK

In late 1977 the American Medical Association, the American Hospital Association, and the Federation of American Hospitals joined together with representatives of health insurers, labor, business, and consumers to form the Voluntary Effort to contain health care costs. The success of this effort has been dramatic.

In the first year of its existence, the Voluntary Effort was successful in reducing the rate of increase in hospital expenses from 15.6 percent in calendar year 1977 to 12.8 percent in calendar year 1978. The latest available data on the Voluntary Effort indicate that the rate of increase in hospital expenses was 13.0 percent in June 1979, which was less than the increase experienced last June, 13.7 percent. The June 1979 increase would have been considerably lower if inflation generally had not accelerated to near record levels. In fact, inflation in the general economy, rather than hospital "inefficiency", continues to be the major obstacle to the success of the voluntary effort.

In the first half of 1978, inflation was running about 6.8 percent. By the first half of 1979, the rate of increase was 3.4 percentage points higher—10.2 percent. The rate of increase in hospital expenses, in contrast, increased only 0.3 percentage points, from 12.0 percent for the first half of 1978 to 13.2 percent in the first half of 1979. This performance was achieved by hospital administrators and physicians, through voluntary restraint and commitment to the goals of the Voluntary Effort.

If inflation had continued at the 6.6 percent rate in late 1977 when the Voluntary Effort was formed, the June 1979 increase in total expenses would have been 11.2 percent, and the increase for the first six months of 1979 would have been 11.8 percent, more than one percentage point below the rate of increase for the first six months of 1978. As these data clearly demonstrate, general inflation in the economy is presently the most important factor in explaining rising hospital expenditures. In other words, it is illogical in the extreme to impose price controls on one segment of the economy while prices in

all other areas are on the rampage. In fact, it is almost incomprehensible that the one segment of the economy which has responded positively to President Carter's call in his January 1978 State of the Union address for "voluntary efforts" to fight inflation is the one which is faced with the imposition of arbitrary price controls. It is therefore not the least bit surprising that half of the Committee—21 members—voted to reject mandatory price controls and to support the Voluntary Effort by voting for the Broyhill amendment.

V. FALLACY NO. 4: H.R. 2626 WILL SUCCESSFULLY REDUCE EXPENDITURES FOR HOSPITAL CARE

Perhaps the most unfortunate and inconceivable aspect of this legislation is that it is unlikely to stem the increases in expenditures for hospital care, but it undoubtedly will have a negative impact on the ability of hospitals to provide care which is needed. It is important to note that various observers have questioned the impact of the Economic Stabilization Program (August 1971 through April 1974) on rising hospital costs.[4] For example, as one commentator has pointed out, the use of hospital services (as measured in adjusted patient days) registered the highest increase in 6 years during fiscal year 1974. ESP was in effect for 10 months of fiscal year 1974.[5]

As asserted above, H.R. 2626 does nothing to curb the existing incentives and appetites for increasing expansion of hospital services and thus it is especially interesting that the rate of increase in total hospital assets increased from 11.0 percent in 1971 to 13.5 percent in 1972 and remained above 11 percent for the duration of ESP.[6] In other words, regardless of the imposition of controls on revenue, hospitals continued to find funds to finance the expansion of capacity which has been found to have an extremely important impact on total hospital expenditures.

Under H.R. 2626, controls under the mandatory program would be on inpatient revenues per admission. One can realistically expect hospitals to attempt to maximize their revenues—possibly just to survive in some cases—by increasing the number of patients admitted. Also, hospitals may try to provide more care on an outpatient basis—and may do so in serious cases where inpatient care would be warranted but costly to provide. In the same fashion, hospitals may be forced to provide some services outside of their institution so that revenues will not accrue to the hospital, although total health care expenses will not be reduced. Other hospitals may find it necessary to admit low-cost patients who would be more appropriately treated on an outpatient basis, thus lowering the hospital's average cost per admission.

The point is a simple one—namely, that it is naive and unfortunate to assume that legislators or bureaucrats can bring about a meaningful reduction in the cost of hospital care simply by ordering that it occur through establishing still another regulatory apparatus. People in this country who need medical care properly will seek it; and, doctors and hospitals will respond as they properly should—by providing it, and

[4] Paul J. Feldstein and John Godderis, Alternatives in Hospital Reimbursement: A New Analysis (A publication of the Council of Community Hospitals, p. 14).
[5] Robert A. Zelten, Ph.d., "Hospital Cost Containment and Hospital Fiscal Management" (A Project Hope publication, 1978, p. 8).
[6] David S. Abernethy and David A. Pearson, *Regulating Hospital Costs; The Development of Public Policy* (Ann Arbor: Health Administration Press, 1979).

getting paid one way or another for doing so, as they must do in order to stay in business. If there is to be a reduction in the cost of hospital care, such a reduction must occur instead through developing systems and mechanisms that give all of the actors in the drama—patients, health care professionals, institutions and payors—appropriate incentives to reduce unnecessary utilization and to use the least costly method of providing needed services.

Even more distressing is that H.R. 2626 will impose this inequitable and unworkable regulatory scheme on an industry already overburdened with regulation. Any hospital which experiences a change in services or capacity which implies higher revenue or rising admissions undoubtedly must request an exception from the Secretary with the associated tangle of red tape. Moreover, the Secretary has a great deal of discretion, not only in granting exceptions, but (incredibly) even in deciding whether and on what grounds to consider a hospital's request for an exception. Applying for exceptions with possible hearings and appeals will be a time-consuming, expensive, and as experience under ESP clearly demonstrated, a frustrating, often fruitless experience for the hospital. Without question, it will be the patients—and the taxpayers—who will have to pay for the excess of regulatory zeal mandated by H.R. 2626.

The vague mandate of this legislation allowing the Secretary to specify whatever grounds for exception he or she may desire is indicative of the most objectionable aspect of this bill. As pointed out above, the bill's revenue caps are unlikely to provide sufficient control to ensure that hospitals will cut their costs by cutting waste. In fact, the revenue controls generally provide a counter-incentive to eliminating unneeded hospitalization or services. However, the legislation provides tremendous latitude to the Secretary to modify or otherwise manipulate the actual revenue limits imposed on hospitals.

These modifications include adjusting the components or the weights in the hospital market baset index—the mechanism used to "pass through" the costs of goods and services hospitals buy—and modifying the factors used to group hospitals for purposes of the "efficiency" adjustment. Perhaps most importantly, the bill allows the Secretary to establish, by regulation, adjustments "to reflect changes in the number of admissions," or, in other words, authority to reduce allowable revenue per admission for hospitals experiencing increased admissions, no matter what the reason for that increase may be.

Due to the bill's lack of impact upon the existing incentives the health care system provides, and the resulting inability to actually stem rising expenditures for hospital care, it is clear that HEW will have every incentive to use these adjustments to screw down tighter and tighter on hospital revenues in order to achieve the inflated claims made in advocating passage of H.R. 2626. In this sense the true nature of H.R. 2626 becomes clear—the bill grants to the Secretary of HEW the discretion, and the power, to become directly involved in the management of this country's hospitals without achieving the objective to which the bill is supposedly addressed—reducing expenditures for hospital care through the application of revenue caps. It is inconceivable that anyone believes that the Federal Government can do a better job running over 6,000 hospitals than can those who presently are administering these institutions.

The main question, therefore, is whether establishing the Secretary as a hospital czar is the most desirous or appropriate way to ensure that the American people receive the greatest value for the dollars they spend on hospital services.

While the health care market is admittedly imperfect due to the unrestrained demand for hospitalization generated by current policies, this is an argument for changing those policies, rather than adding a new layer of federal controls. The hospital system is currently fraught with problems, because the incentives in the system are biased toward maximizing expenditures. Attempting to cap the system without changing the fundamental incentives of patients and physicians ordering services will only ensure that the quality of the product declines. The Hospital Cost Containment Act, because it fails to deal with the underlying problem of excessive demand for services, cannot possibly deliver on its promise of a quality product for fewer dollars. It can only ensure that expendtures keep rising while the product deteriorates.

This cannot possibly be what the Congress—or the American people—hope to accomplish in dealing with the problem of rising hospital costs.

James T. Broyhill.
Samuel L. Devine.
Tim Lee Carter.
James M. Collins.
Tom Corcoran.
Gary A. Lee.
Tom Loeffler.
William E. Dannemeyer.
Carlos J. Moorhead.
Dave Stockman.
Clarence J. Brown.

THE ADDITIONAL MINORITY VIEWS OF THE HONORABLE DAVE STOCKMAN

When viewed in the abstract, it is difficult to imagine why anyone would oppose efforts to constrain the rise in the cost of hospital care to the American people. Even putting total social costs aside, the ever-rising volume of dollars pouring through the federal budget into the hospital system poses a severe threat to the ability of the federal government to meet other pressing domestic and foreign policy objectives. The situation appears to cry out for strong and dramatic action.

Armed with this perception, the President and the media have taken the Commerce Committee strongly to task for its failure to report the Administration's Hospital Cost Containment Act swiftly. They viewed last year's defeat in Committee as a victory by parochial special interests over the compelling public interest in constraining hospital expenditures. This perception helped to fuel the massive Administration effort of this year that finally succeeded in levering the bill out of the Commerce Committee and to the floor.

Before my colleagues accept this vote as an endorsement of this bill's merits, however, I would urge them to look below the surface of this legislation to determine just what effect this bill would have on our nation's health care delivery system. For despite its noble objective, this bill would not markedly improve our hospital cost problems at all. Rather, because its simplistic "solution" to the hospital cost problem is based on a wholly mistaken understanding of why things are going wrong, it will simply mire the system knee-deep in regulation, generate perverse cost-increasing incentives for hospitals, and hopelessly obscure the task of finding workable solutions to the real underlying problem. As a result, far from being a promising way of achieving hospital cost savings and cutting sharply into the inflation rate, this bill is actually the worst possible response to the problem of rising hospital costs.

1. THE CASE FOR HOSPITAL-SECTOR-ONLY ECONOMIC CONTROLS HAS EVAPORATED

When the Administration unveiled its Hospital Cost Containment Act in the spring of 1977, the notion of applying special treatment to rising costs in the hospital sector had a certain surface plausibility. At that time, the annual rate of increase in total expenditures in hospitals—HEW's measure of "inflation"—was running in excess of 15 percent, while the overall rate of price increases in the economy, as measured by the CPI and the GNP implicit price deflator, was in the 6–7 percent range. Given the size of this "inflation gap" between the hospital sector and the rest of the economy, it seemed reasonable that the rise in hospital costs indicated a special problem requiring a unique solution.

In the last thirty months, however, this "inflation gap" has completely disappeared. In fact, the rate of increase in hospital expenditures per case has actually fallen below the overall rate of inflation, rising 12.3 percent in the 12 months ending in June, compared to the 13.2 percent CPI increase over the same period.

There are two reasons why the gap between the rate of increase in hospital costs and the overall inflation rate has closed so quickly. First, the rate of increase in 1977 was itself abnormally high. Hospital expenditures prior to the 1976–1977 period had been subject to particularly stringent limits under the Economic Stabilization Program of 1973 and 1974. As in most other sectors of the economy, the lifting of the controls induced a short-lived spurt of expenditures increases as hospitals made otherwise normal purchases that had been deferred during the years of controls.

The second reason for the narrowing of the inflation gap is the success of the Voluntary Effort by the hospital industry to hold down hospital costs. Because of these efforts, hospital expenditure increases have been cut from 15.6 percent in 1977 to below 13 percent this year, even though the inflation rate in the overall economy has doubled in the 18-month life of the voluntary program.

The disappearance of the inflation gap that supposedly justified stringent hospital revenue controls demonstrates the dubious nature of attempts to control prices in only one sector of the economy. Single-sector controls cannot constrain the pass-through inflation in the prices of goods and services that hospitals buy from uncontrolled sectors of the economy. Due to the fact that more than 75 percent of all hospital costs represent purchased labor, fuel, food and supplies—which reflect current economy-wide price and inflation conditions—the only way to control hospital costs is either to deny hospitals the right to recover these costs, or else to force a reduction in the quantity—and quality—of services offered by hospitals. Given the alternatives—bankrupting hospitals or forcing cuts in the quality of medical care available to the American people—the notion of hospital-only price controls is really totally worthless as a means of combating inflation.

2. LASHING INFLATION WITH A WET NOODLE—A FRAUDULENT ARGUMENT

Even if a means could be found to constrain the rate of hospital expenditure increases without damaging our health care delivery system, it would still be preposterous to expect hospital cost controls to have any measurable impact on the rate of inflation. The hospital cost component of the Consumer Price Index accounts for less than 4 percent of the total index weight, and hence even a massive reduction in the rate of increase in hospital prices would have only a miniscule impact on the behavior of the total index. At the present time, a cut in the rate of increase from the current level of 13 percent to 8 percent—a massive retrenchment that would mean bankruptcy for a significant share of the nation's hospitals, or a stringent reduction in the level of hospital services available to many needy patients—would only lower the CPI from 13.2 percent to only sightly less than 13.1 percent. Such a questionable gain would hardly justify the incredible hardships the nation's health care system would have to endure to achieve it.

The Hospital Cost Containment Act, of course, would achieve nowhere near such a massive reduction. For this reason, an econometric forecast prepared by Data Resources, Inc., the noted economics consulting firm, indicated that even if the Administration's bill as originally introduced lived up to the Administration's wildest expectations, the bill would only shave an average of less than 0.1 percent off the inflation rate between now and 1984. Hence, the Hospital Cost Containment Act can simply not be justified as even a minor weapon in the fight against inflation.

3. THE TOPSY-TURVY LOGIC OF HOSPITAL COST CONTAINMENT: REWARD THE FAT, PENALIZE THE LEAN

On the theory that hospital revenue controls actually work, the Administration's bill as reported by this Committee provides an automatic exemption to the ten states that have enacted their own versions of mandatory cost containment programs before January 1, 1979. Moreover, these states would retain their exemption under this provision for the life of the program, even if they subsequently prove totally ineffective. The sole requirement for the exemption is that the state's enabling statute remain on the books. A comparison of hospital costs in these ten exempt states raises serious questions about why these ten states are in fact singled out for an exemption from the provisions of this bill. For in terms of costs, these states are hardly models for the nation; on the contrary, they are undoubtedly the worst offenders:

1978 Average Cost per Admission

10 exempt States	$2,060
Other 40 States	1,587
10 lowest cost States	1,163

Source: American Hospital Association Annual Survey.

In short, these states average 30 percent more per typical admission than other states, and account for better than 25 percent of all hospital expenditures despite the fact that they experience fewer than 20 percent of all hospital admissions. Yet under this bill, they are prospectively given carte blanche to decide their own fates. By contrast, the ten lowest-cost states without mandatory control programs have average per-patient costs 44 percent below the level of the exempt states, but are almost certain to feel the heavy hand of federal regulations under the bill as proposed.

Another way to highlight the perversity of concentrating on "rates of increase" to the exclusion of other more meaningful factors is to examine the actual amount by which hospitals in the various states would be allowed to increase their expenditures for patient care under this legislation:

Allowable increase under an 11.6-percent cap

1978 expenses/admissions	$2,060
Allowable increase	234
10 lowest cost States:	
1978 expenses/admissions	1,163
Allowable increase	135

Source: American Hospital Association Annual Survey.

As this table indicates the nation's high cost states would be allowed cost increases 75 percent greater than the nation's lowest cost states. This is a sad form of "cost containment."

In all, by measuring hospital performance in terms of percentage changes from pre-existing levels rather than in terms of actual costs, the system proposed in this legislation rewards the excesses of past behavior, without regard to the efficiencies—if any—in a hospital's current practices.

4. THE "VOLUNTARY" FORMULA CONTROLS ADMISSIONS—NOT COSTS

This program is advertised as only a "standby" measure, triggering mandatory controls only if hospitals fail to keep their total cost increases within the bounds of voluntary limits established by the Secretary. Yet performance against this "voluntary standard"—which will be measured in terms of total hospital expenditures rather than hospital unit prices—has about as much reliability as a predictor of efficiency as would throwing darts at an alphabetical list of the nation's hospitals.

By measuring performance solely on total expenses, the Administration ignores the extreme fluctuations from year to year in hospital expenses due to substantial variations in the number of patients that hospitals serve. This is dramatically illustrated in the table below, drawn from data on actual hospital experiences in 1977 and 1978. Had the 11.6 percent expenditure limit been in effect in 1978, the first five hospitals listed would have "failed" the voluntary test and been subject to mandatory controls for 1979, due solely to their large admissions gains. By contrast, the second five would have "passed," due to significant admissions declines. Yet in terms of actual expense growth per case treated, the "failed" group had expense growth 52 percent lower than the group that would be exempted from mandatory controls.

There is an obvious lesson here for hospital administrators, should they ever be faced with the "voluntary" program provided in this bill: the best compliance strategy will be to keep as many sick people as possible out of their hospitals.

RATES OF INCREASE IN TOTAL EXPENDITURES AND EXPENDITURES PER CASE, 1977–78

[In percent]

	Total expense change	Admissions change	Expenses admission
"Failed" group:			
Hospital A	14.6	7.2	6.9
Hospital B	14.1	6.9	6.8
Hospital C	15.3	4.0	10.8
Hospital D	17.5	13.3	3.8
Hospital E	15.0	3.5	11.2
Group average			7.9
Exempt group:			
Hospital F	9.8	−7.0	18.0
Hospital G	2.0	−12.3	16.3
Hospital H	5.1	−8.3	14.7
Hospital I	8.3	−3.4	12.2
Hospital J	8.0	−10.2	20.3
Group average			16.3

Source: American Hospital Association Guide to the Health Care Field, 1979.

5. THE NEW LUDDITES AT HEW: THE INCREDIBLE ARGUMENT THAT 80 PERCENT OF HOSPITAL TECHNOLOGY AND SERVICE GROWTH HAS BEEN PURE WASTE

A hospitals-only control program obviously cannot control the prices paid for wages, fuel, food and other items without causing strikes by unfairly-treated workers, or leaving hospitals stranded without adequate supplies. Hence, the Administration's program simply "passes through" these costs based on a set of wage and non-wage "market basket" formulas that attempt to measure the rise in input prices that hospitals actually face. With input prices completely passed through, the only expenditures left for the controls to bite are those outlays in excess of price inflation that hospitals have traditionally made—for more and better-trained employees, new technology, and other service intensity-increasing additions—to improve the quality of hospital service.

In this decade, hospitals have indeed upgraded their product rapidly, with intensity-increasing expenditures running in the range of 5% annually. Yet since the only way that a control program that passes through unit input prices can reduce expenditures at all is to cut severely into this trend, the Hospital Cost Containment Act proposes to slash the rate of allowable intensity growth to 1% annually under the voluntary program—and then to eliminate intensity increases altogether if hospitals fall under mandatory controls.

Now, given our traditional interest in improving the quality of health care available to the American people, and the myriad explicit federal policies that support the extension of quality medical care to those who are currently underserved, it would seem contrary to every notion of equity to constrain the rate of growth in the quality of hospital services so severely. Yet forced by its inability to control input prices in a single-sector control program to make cuts somewhere, the Administration has been forced to argue that 80 to 100 percent of all growth in the quality and intensity of services in this decade has in fact been waste. Only by arguing that the great majority of intensity-increasing expenditures of the last ten years have been absolutely worthless can it hope to justify its proposed elimination of virtually all quality improvements in hospitals over the life of this program.

While this theory has found a certain amount of support among those who generally view new technology with suspicion, the simple facts dramatically contradict the notion that improvements in hospital services have generated staggering costs without benefit to the public.

For example, the operation of coronary intensive care units and improved patient monitoring equipment have been a large part of the increase in hospital service capabilities. Yet an examination of hospital discharge statistics demonstrates that thousands of lives have been saved by these high-technology facilities. In the last fifteen years, as a result of the introduction of these life-maintaining units, the in-hospital rate of death among heart-attack victims has fallen 30 percent.

Similarly, neonatal intensive care units have made an equally important contribution to the significant decline in infant deaths within seven days of birth. Within just ten years since the introduction of these specialized units, such deaths declined from 15.9 per 1,000 births to 10.0, or a dramatic 37 percent.

Further, the improvement in hospital service capabilities represented by these consistent quality improvements have often resulted in decreased costs for the total economy. Today, for example, sophisticated physical therapy procedures are allowing many individuals to return to productive work who otherwise would be permanently incapacitated. The savings in terms of disability-associated costs alone more than justify the dollars spent in providing these services.

In all, it is ludicrous for HEW to clain that the great majority of intensity-increasing expenditures in hospitals are valueless and essentially wasteful. It is equally ludicrous for the Administration to propose to freeze the current level of technology and service capability in its track as its sole method of "cost containment." Far from being a discriminating approach to slowing the rate of increase in hospital costs, such an approach is a blunderbuss blast at needed improvements in hospital care quality and efficacy.

Sensing this fundamental objection to its proposals, the Administration has gone to great lengths to convince the Congress that their proposal for a sharp limit on hospital service intensity increases is a "net" limit. By this they mean that hospitals can finance intensity increases far in excess of the 1 percent limit if only they are willing to eliminate "waste" from their existing operations.

The waste they propose to eliminate, however, turns out to be a sheer bureaucratic concoction. In testimony before the Health Subcommittee on this bill, Maryland Hospital Commission Administrator Harold Cohen indicated that in a detailed budgetary review of Maryland hospitals that was conducted as part of the Maryland mandatory cost control program, the hospital analysts of the Commission could identify only about 2 percent of total hospital costs as being "unreasonable." Given that Maryland hospitals were at the time among the highest-cost hospitals in the country, this is hardly encouraging evidence that there will be enough waste lying around to be cut in the name of further intensity increases.

It should also be noted that financing new hospital services by "waste substitution," even if feasible, is essentially a one-time capability. After the "waste" has been converted to savings applied to new equipment and staff, no further waste will be left to finance continued product quality improvements. Far from being a reservoir of potential financing for hospital service capacity increases, "waste substitution" is instead a sure-fire formula for stagnation in—or even for contraction of—the quality of hospital services.

6. RUBE GOLDBERG STRIKES AGAIN

The rhetoric accompanying the Hospital Cost Containment Act suggests that this program amounts to an interim program in which simple voluntary, or standby revenue growth formulas will be imposed pending more permanent cost-containing policy changes in the near future. Yet even a quick scan of the pages of obscure and complex formulas for compliance contained in the bill will confirm just the opposite conclusion: the sheer administrative complexity of this bill would make both HEW implementation and hospital compliance a staggering nightmare of hyperregulation.

Under this bill, before a hospital would know even remotely where it stands relative to either the voluntary limits or the mandatory ceil-

ing/penalty aspects of the bill, four major sets of administrative determinations would have to be made:

A. Eligibility for front-end exemption

A hospital would be exempt from mandatory controls if it fit one of the following categories:

(*a*) It was located in one of the ten states that enacted mandatory cost containment programs before 1979.

(*b*) It was located in a state with a mandatory program enacted in 1979 and thereafter, if the program met a laundry-list of conditions laid down by the Secretary. Hospitals, of course, would not know until a waiver was finally granted whether it was in fact exempt or not under this provision.

(*c*) It was involved in a demonstration project under section 213 of the Social Security Act.

(*d*) It turned out at the end of the year that at least 75% of its patients were enrolled in a Health Maintenance Organization (HMO).

(*e*) It was located in a non-urban area and averaged fewer than 4,000 admissions per year for each of the last three years.

The result of all these front-end exemptions, of course, is that better than half of the nation's hospitals, comprising a major share of total hospital expenditures, would be exempt before the program ever began. Determining whether the hospital in fact *qualified* for its exemption, however, could conceivably take years.

B. Secretarial determination of three key formulas

In order for the Secretary even to begin publishing limits for individual hospitals, he must first work out the statistics that would be used to fill in the blanks in many of the limit-computing formulas, which are essentially left to the Secretary's discretion.

(1) *The nonwage marketbasket.*—To begin with, the Secretary must construct a "nonwage marketbasket," which is really a specialized producer price index for hospitals, in order to determine just how much allowance is made for passing through nonwage costs. Not only must he determine accurate measures of the changes in hospital input prices, but the formula also calls for him to establish the weights with which each price element will be considered in the index. Given the fact that an artifically low weight for, say, energy costs, could artifically force down both the voluntary and mandatory limits for New England's hospitals below starvation levels, litigation attacking each judgment call the Secretary makes in determining the formula would be inevitable. Considering that any weight given by the Secretary to a marketbasket item will harm some hospitals and help others, controversies dragging on for years on each tenth of a percentage point are not only possible, but odds-on favorites to occur. Hence, the great majority of hospitals will undoubtedly learn their final 1980 limits in the fall of 1983, at which point it will be very difficult for them to control their 1980 costs in such a way as to ensure compliance.

(2) *The "efficiency" adjustment.*—Operating on the theory that hospitals should be judged in light of how well they perform relative to other similarly-situated hospitals, the bill calls for the Secretary to distribute hospitals into "peer groups," and then to select certain

cost categories with which to make comparisons among hospitals. "Efficient" hospitals discovered through this exercise would be given up to a 1% increase in their mandatory limits as a "bonus"; hospitals determined to be "inefficient" would have their mandatory limit slashed by as much as 2% as punishment for their sins.

Given the fact that decreasing a mandatory limit would in effect drive the level of allowable increase well below the overall inflation rate—and the fact that each percentage point can mean hundreds of thousands of dollars in revenue to a hospital—there will be considerable interest among the various parties involved over how the groupings are made and which expenses are selected for comparison. The arbitrary nature of this method of deeming hospitals "efficient" will only exacerbate the rush to the nearest District court, which will then spend the next four years determining bonuses and penalties for each of thousands of hospitals that could be potentially subject to controls.

(3) *The admissions adjustment formula.*—After the marketbasket indexes have been adjusted for "efficiency," the bill next calls for the Secretary to make adjustments to a hospital's mandatory limits based on whether a hospital's admissions increased or decreased over the year the program went into effect. As one might otherwise surmise, however, the bill does not call for a higher limit for those with increasing admissions; quite the contrary. Operating on the theory that unit costs falls as admissions rise, the formula calls for a lower increase limit for rising admissions, and a somewhat higher limit for hopitals whose admissions decline.

The bill is silent on a number of key questions, however, such as how the adjustment will be computed, how much of an adjustment will be computed and how much of an adjustment the Secretary should make, and provides no guidance other than the fact that the Secretary is given carte blanche authority to make adjustments for admissions and "such other factors as he deems appropriate."

The net result of all these calculations, adjustments, bonuses, and penalties is to give the Secretary almost limitless authority as to where each hospital's madatory control limits should be set. It would be charitable to assume that the Secretary will make a good faith effort to be fair to all concerned. Yet because of the wholly arbitrary and unjustified nature of *all* of these tortuous judgment decisions, the Secretary is given widespread authority—both explicit and implied—to tinker with the formulas to make them more palatable to all concerned.

C. The exceptions process

If a hospital believes that it has been unfairly penalized by the mechanistic operation of the formulas that the Secretary devises, it can appeal to the Secretary to grant an exception. Recognizing the tremendous potential for mischief inherent in the formulas, the bill provides the following partial list of reasons why a hospital might be given special consideration:

(1) If national prices change data differ markedly from local conditions, a hospital can ask the Secretary to use local data, if available.

(2) If hospital expenses rise due to the cost of providing charity care to indigent patients or because bad debts are rising, the hospital can appeal to have its limits computed net of these expenses.

(3) If a hospital gets the approval of a state health planning authority to terminate unneeded facilities, it can apply to the Secretary to retain the cost of providing those services in the hospital's accounting base to help it comply with the limits.

(4) If the hospital has had a new capital expenditure approved by the State prior to enactment of the bill, it can appeal to have the capital costs of the project passed through under the mandatory limits. If it is a teaching hospital, it can also ask for the pass-through of the operating costs of such projects.

(5) If a nearby hospital closes or severely curtails its activities, another hospital can apply for special treatment to cope with the ensuing influx of patients.

(6) Exceptions are also potentially available for several other categories of unusual circumstances:

(*a*) A "significant change" in capacity or character of services available in the hospital.

(*b*) A major renovation or replacement of the hospital's physical plan.

(*c*) A significant shift in the proportion of revenues coming from various sources.

(*d*) A significant expansion of insurance coverage by any or all of the carriers who insure hospital patients, and

(*e*) A hospital is a sole community provider that would otherwise go bankrupt.

Clearly, only the nation's least enterprising hospitals would fail to attempt to gain an advantage under at least one of these myriad special circumstances provisions. The resultant flood of exemption requests to HEW would undoubtedly swamp that Department in record volumes of red tape. Should HEW fail to deal effectively with these issues to the hospital's satisfaction, however, and cause a hospital to be assessed a penalty it feels it does not deserve, the hospital of course has recourse to a lengthy appeals process. Should a hearing before a Provider Reimbursement Review Board fail to bear fruit, the hospital moves next to a full-blown hearing—complete with cross-examination of witnesses—before the administrative review unit within the Department. Failing successful disposition at this phase, the Secretary is then guided to negotiate the penalty amount with the hospital; failing satisfactory resolution, the hospital is entitled to judicial review.

Nor are the financial matters the only potential source of boondoggles of epic proportions. A hospital is prohibited under the bill from pursuing certain otherwise logical courses of behavior to escape the effects of revenue controls. These include:

(1) Deleting services without State approval

(2) Reducing its load of charity-care patients

(3) Refusing services to people who owe the hospital delinquent payments for previous services rendered

(4) Reducing the number of high-cost cases treated in the hospital

(5) Refusing emergency room services to those unable to pay.

Should HEW catch a hospital in any of these dodges, the hospital can be cut off from further reimbursement for treating Medicare and Medicaid patients. Given the incredible severity of this penalty, of

course, the hospital is provided with a full set of due process rights that ensure that such cases are tangled up forever in the bowels of HEW.

Should HEW inadvertently miss an infraction, however, a private right of action to challenge the hospital's behavior in the courts is granted. The severe risk of nuisance aside, settlement of those cases in which legitimate differences of opinion exist with regard to the effect of the hospital's admissions policies ensures that these provisions, as well, will provide a promising new source of income to the legal profession.

In all, given the fact that the provisions of this bill apply, in whole or in part, to some 6,000 hospitals nationwide, it is certain to engender a tangle of bureaucratic hyperactivity and legal warfare that would completely demolish any "savings" that otherwise might be achieved.

7. THE GAMES HOSPITALS PLAY

No single piece of legislation, of course, could possibly anticipate and forstall the way in which ingenius Americans devise strategies to evade the consequences of regulations. Unfortunately, due to the severity of the controls proposed, this bill provides a massive invitation to evasion strategies that are uniformly counter-productive, both the quality of health care delivery, and ultimately to total system costs.

A. Business as usual—over the edge

The underlying assumption behind hospital cost containment is that, faced with absolute limits, physicians and hospital administrators will be forced to behave more efficiently if they hope to continue providing quality service. The experience of New York and Massachusetts, however, indicates that nothing of the kind is likely to take place. Faced with the heaviest revenue limits in the nation, New York hospitals have not fundamentally changed their behavior so as to eliminate the frivolous and emphasize the necessary. Rather, they have done their best to continue business as usual, raiding hospital endowment funds with abandon and cannibalizing their depreciation accounts to finance their historic level of care. The unsurprising result is that 80% of all New York hospitals are now found to be running in the red, with many teetering on the brink of financial disaster. It takes little imagination to see the financial chaos that would await should such conditions be replicated nationwide.

B. Debundling

As noted above, the bill attempts to forbid hospitals from discontinuing needed services as a means of freeing up revenues to help the hospital survive under revenue controls. Under this program, such restrictions would be sorely needed, for the evidence from the current state mandatory programs indicates that rolling certain classes of services—or even whole departments—outside the hospital billing structure to continue unchecked on their own is a favorite strategy of hospitals in dealing with revenue limits. In New Jersey, for example, a hospital faced with cost limits "discharged" its staff of radiologists, only to contract with them as a group practice to provide radiology services to the hospital. Since the physicians billed the patients di-

rectly, the costs failed to show up in the hospital revenue totals, and the hospital achieved some $300,000 of annual budget slack to apply to other departments. The patients of the hospital, however, could not appreciate these economies, for the bills the patients received for radiological services on the fee-for-service basis by the group practice of radiologist were soon roughly twice as high as when the radiologists, then salaried, allowed the hospital to bill for the service.

As a check on this sort of thing, the Administration proposes to subtract from a hospital's revenue base the cost of any services "debundled" in this fashion, unless the services are identified as unnecessary by a state health planning agency. This approach to the problem, however, will have only a limited impact. The plain fact is that most hospital accounting systems contain certain "cross-subsidy" elements; that is, they make profits on certain departments which they use to continue to operate other departments or services at a loss. If, under the system proposed by the Administration, a hospital chose to spin off services that are running in the red, it could conceivably obtain as much as $3.00 cost relief for each $2.00 of revenue subtracted from its base. Given the stringency of the proposed revenue limits, the need to make every dollar count would still provide a strong incentive for debundling of departments with operating deficits. The result in total health care system costs, of course, would be a significant net increase.

C. Admissions games

While the "anti-dumping" provisions of the bill, designed to prevent hospitals from unloading patients as a means of lowering costs, are a good-faith effort, they cannot possibly cope with all the manipulations that hospitals could devise to keep their costs in check.

Under the voluntary limits, the measurement of the limits against total expenses provides a powerful incentive to limit or shut off hospital admissions growth. While the anti-dumping provisions prevent this from being achieved by refusing emergency admissions, a significant share of hospital admissions are highly elective. Moreover, because most of the dumping detection mechanisms are based on the percentage composition of a hospital's patient caseload, freezing the status quo becomes an admirable means of remaining in compliance.

In rapidly growing areas, of course, the burden of such a policy would undoubtedly fall upon the poor, or those who otherwise posed the potential for providing insufficient revenues to cover expenses. While hospitals would never dump sick patients into the streets to meet their financial requirements, the incentives under the voluntary limits would insure that, at the margin, highly elective admissions decisions would be made in favor of the status quo.

The situation is somewhat different under mandatory controls. Because the limits are based on hospital revenues per admission, there would be no incentive, per se, to hold down the total number of admissions. Given the fact that an admission adjustment formula will undoubtedly constrain the allowable revenues for additional patients at less than a level proportional to current year per-admission costs, however, increasing the number of low-cost admissions whenever possible would be particularly attractive. Unfortunately, this would encourage hospitalization, at the margin, of those for whom hospitalization is highly elective, resulting in the hospitalization of many pa-

tients who might otherwise be effectively treated on an outpatient basis. Nor would a hospital necessarily run afoul of inducing a shift in its "class-of-payors" composition by increasing low-cost admissions. On the contrary, the percentage of the routine costs such patients would predominantly generate is usually much more fully compensated by Medicare, et al., than much of the exotic treatment required for the seriously ill. In all, should this bill be enacted, we can expect a marked increase in the number of "questionable" admissions that HEW so often decries as a leading element in the rise of hospital costs.

D. Manipulating the wage pass through

Because of the unique status given to non-supervisory wages under this bill, playing games with the hospital labor mix would become a profitable undertaking should mandatory controls be triggered.

Since at least the Second World War, the historic trend rate of wage increases has been roughly 1 to 3 percent higher than the overall rate of price inflation in the economy, due to real wage gains offered to employees to reflect rising productivity. It is not to be expected that the relative change in the wage vs. non-wage marketbaskets established under this bill would deviate from this general rule. Thus, if a cost is classified as a "non-supervisory wage," it would be allowed to increase faster than if it were labelled "non-wage cost."

Now, it so happens that many hospitals currently save money—for domestic services, laundry, maintenance, etc.—by paying outside contractors to perform services in cases where full-time in-house staff would be too costly. Given a relatively higher limit for in-house staff charges than for contracted labor services, there would be a strong temptation, at the margin, for hospitals to ignore the overall economies and bring the costs inside the hospital structure, where they could be used to pad the amount of hospital budget passed through as labor costs.

A second temptation, of course, would be to forego those opportunities in which increased mechanization and other substitutions of capital for labor would otherwise tend to decrease total costs. Far better to keep the overall budget higher as a pad against future contingencies than to reduce labor outlays—and tighten up the hospital's limits—by achieving otherwise reasonable total system savings. In all, by creating a consistent bias in favor of maximizing costs associated with non-supervisory wages, the wage pass through provides a number of opportunities for hospitals to raise their costs with impunity.

8. HOSPITAL REVENUE LIMITS—A CAP ON A PRESSURE COOKER

While the perverse incentives, likely bureaucratic excesses, and overall cost-increasing potential of this bill provide sufficient justification to reject the Administration's proposal, they are not in themselves the major reason why H.R. 2626 is so thoroughly defective. Rather, they are merely symptoms of an underlying flaw inherent in any and all efforts to constrain hospital costs by placing limits on the total amount of dollars in the system.

The reason behind the rapid rise in hospital costs is not some unexplained and intractable hyperinflationary force that must be starved of revenues until its back is broken. The rise in hospital costs is not

mysterious at all, but instead the reasonable and predictable outcome of the interaction between the structure of our health care delivery system and federal health care financing policy.

In an effort to devise a system of providing health care to the American people on the basis of need instead of on the basis of ability to pay, we as a nation have imbued in our medical and hospital communities a strong ethical bias toward using all available resources to provide whatever medical care is needed to those with health problems. When it was concluded that the voluntary efforts of these practitioners and their philanthropic supporters were insufficient to ensure access to quality care for all of the American people, the Congress went further, providing significant new financing sources to ensure that no one would have to be refused care for lack of financial resources. Substantial health insurance coverage has been provided to the great majority of the American people through Medicare, Medicaid, and the multi-billion dollar annual tax subsidies to private health insurance. The great majority of this insurance operates by providing virtually dollar-for-dollar reimbursement to providers—particularly hospitals—for any "reasonable" costs they incur in the course of providing needed care.

As a result of this virtually total coverage for almost all costs, the clinical decisions of physicians are made in an environment almost totally free of cost considerations. In deciding what services to provide the patient—and what services to order from the hospital on the patient's behalf—the physician is faced with a situation in which he is almost ethically compelled to order additional services whenever in doubt. This has almost nothing to do with the fact that the physician's own income is often increased as a result of supplying additional services. Rather, if he can order an additional service that might help, and the cost to the patient, the hospital, and the physician is infinitesimally close to zero, how else should he proceed? Given a choice of fulfilling his ethical responsibility to his patient or serving some generic obligation to hold down the total cost of health care, the obligation to the patient will win almost every time.

While we might conclude in the abstract that we wish to continue the express federal support for just such a policy of "whatever care is needed," we are beginning to discover that the society might just not be able to afford it.

It should be obvious, however, that attempting to regulate this cost simply by limiting the volume of dollars flowing into the system will be totally fruitless. While a revenue cap may make a hospital administrator concerned about the dollars available to serve patients, it will make not one iota of difference to the physician and his patient, who will continue to be faced with the same care-maximizing incentives. To expect that the administrator, in the name of economy, will somehow discipline the physician and patient to the new cost realities is hopelessly naive. As observed in the New York case, the more likely outcome will be for the financial resources of the hospital to be completely consumed as physicians and patients continue to respond to the natural incentives afforded them by the system.

Attempting to contain hospital costs through a revenue cap without affecting the underlying incentives in the total health care system,

therefore, will be tantamount to attempting to slow down the cooking of a pot roast by closing the valve on the pressure cooker. The constant incentives to maximize care will blow the containment program apart long before a single dollar of "savings" is ever achieved. In the process, however, we would undoubtedly do severe damage to the existing structure of the system.

For all these reasons, it is critically important that we turn our attention to ways of restructuring the incentives in the system to reintroduce cost-consciousness to the patient—and hence to the physician—to provide an effective balancing force to the otherwise natural incentive to maximize costs. Proposals are now surfacing in the Congress to achieve such cost-consciousness without forcing the poor and aged to face undue financial burdens—or forego needed care—in the name of cost containment. Enactment of the Hospital Cost Containment Act, to then extent that it would not only divert the energies of the Congress from more effective solutions but would also do grave damage to our hospital care system in the process, would be extremely counter-productive to these needed changes. Instead, we should move forward at once to restore a cost-conscious balance to the system through needed fundamental reforms.

The first crucial step in this direction is to resoundingly defeat the Hospital Cost Containment Act of 1979.

DAVE STOCKMAN.

H.R. 2626—SEPARATE VIEWS

This bill undeniably has a strong surface appeal. The desire to "do something" about inflation and the rising costs of medical care runs across the political spectrum. Virtually everyone (except for those motivated purely by financial self-interest) is in favor of reducing waste and inefficiency in hospitals and is opposed to a continuation of the high rate of increase in costs which has prevailed in recent years. Why then do we oppose this bill?

We urge the rejection of H.R. 2626 because it is the wrong response to the hospital cost problem. This bill is simply not the solution it purports to be, but rather is yet another example of throwing regulations at a problem. It promises to have no significant effect on inflation. It would not make long-term reforms in the incentives which drive hospital costs. Nor is it a temporary measure yielding immediate savings. Any savings which might eventually result from passage of this bill would not be achieved through the elimination of waste but by preventing improvements in the quality of hospital care. Even if a policy of imposing a percentage limitation upon hospital revenues is thought to be desirable—and believe that it is not—this bill is so riddled with exceptions and loopholes that it would be profoundly unfair and arbitrary in its application. Furthermore, it would reward hospitals—and regions—having the highest costs and severely squeeze those which have kept costs down.

LITTLE EFFECT UPON INFLATION

A study conducted earlier this year by Data Resources, Inc., a highly regarded econometrics firm, found that even if the Administration's cost savings estimates for H. R. 2626 as introduced were correct that it would lower the Consumer Price Index by an average of less than one-tenth of one percent per year. The actual savings which might result from passage of this bill would be far less and the impact upon inflation would correspondingly shrink to a negligible level.

The reason why the hospital cost containment bill would not significantly reduce inflation is that hospital cost increases for the most part have not been inflationary in nature. We have not been paying more for a package of hospital services of unchanged quality and quantity. After adjusting for the underlying rate of inflation, the bulk of the increase in hospital costs is clearly due to increased services received by hospital patients. We are simply buying more and better hospital care. Such desirable and life-saving services as Burn Treatment Centers, Neonatal and Cardiac Intensive Care Units, and CT Scanners are expensive, and they are the source of most of the increase in hospital costs. The rate at which we are increasing spending is disturbing, but it is a phenomenon which has very little to do with inflation. To describe this bill as an anti-inflation measure is therefore fraudulent.

EXAGGERATED SAVINGS ESTIMATES

The Congressional Budget Office has estimated that the total savings from H.R. 2626, as introduced, could amount to as much as $24.6 billion over the period 1980–84, far less than the estimates of the Department of HEW. Of that $24.6 billion, only $3.7 billion—about 15 percent of the total—would come in the first two years of controls. However, the actual savings would almost certainly be far less than the estimates of CBO or HEW, because they are both based upon some highly unrealistic assumptions.

The first assumption is that in the absence of controls the rate of increase in hospital costs will continue at the same level as during the period 1964–78. One difficulty with this assumption is that the rate of increase in hospital expenditures has been highly erratic, particularly when broken down into its three components of the hospital market basket, change in admissions, and intensity of services.[1] In fact, when adjusted for changes in the underlying inflationary rate, the rate of increase in hospital costs has dropped by more than half since 1976. This trend may continue even in the absence of revenue controls. A second difficulty with this assumption is that it does not take into account the effect of the National Health Planning System. We are already seeing a sharp reduction in hospital capital expenditures at least partly as a result of Health Planning. Certainly reduced capital expenditures will in time be translated into a slower rate of increase in hospital revenues.

Another unrealistic assumption is that hospitals will not achieve revenue reductions by shifting services from an inpatient to an outpatient basis or otherwise evading the controls. In other words, reductions in hospital costs might be gained by simply providing certain services outside the hospital, yielding no reduction at all in the total cost of health care. Because there was no way to estimate the magnitude of such shifts they were simply left out of the savings estimates.

Hospitals in States having mandatory controls would be treated more leniently than hospitals in other States. This difference in treatment should further reduce the net savings, but again it was not taken into account in the savings computations.

It was also assumed that although the bill provides for an exceptions process that no exceptions to the revenue cap would be granted.

When all the assumptions are examined, it is apparent that even the CBO savings estimates are extremely optimistic.

UNFAIR TREATMENT OF HOSPITALS

While the net savings from this bill would be relatively slight, it could have severe effects upon some of the hospitals brought under controls. In practice the controls would inevitably be unfair, because the same percentage limitations would be applied to hospitals in very different situations. Hospitals with a history of high costs would be permitted the largest increases in revenues. On the other hand, hospitals which have had low costs in the past would be penalized. In this respect the revenue limitations resemble a kind of Procrustean bed. They assume a uniformity among hospitals which simply does not

[1] *Controlling Rising Hospital Costs,* CBO Budget Issue Paper (September, 1979) p. 5.

exist. Attempts to reduce the arbitrariness inherent in the approach to cost containment taken in this bill simply lead to further inequities. A few examples illustrate this point: (1) Non-supervisory wages would not be controlled under the bill, although they have been rising rapidly and wages comprise over half of all hospital costs; (2) One component of the permitted increase in expenditures is the population change in the area where the hospital is located; however, "area" is defined as the SMSA or county in which the hospital is located, not the actual service area of the hospital, in which the population change may be dramatically different; (3) small rural hospitals are excluded, even though their costs are rising just as fast as other hospitals; (4) States with Mandatory Cost Containment Programs are grandfathered out of the bill, even though their hospital costs may be increasing more rapidly than in other States; (5) all HMO hospitals would be excluded from the bill without having to individually demonstrate that their costs are actually lower than other hospitals.

In attempting to deal with one of the perverse incentives which this bill would create, a provision was added (Section 313) which prohibits a hospital from changing its admission practices in any way which would reduce the proportion of its patients who are unable to pay for services. While the purpose of this provision is to prevent "dumping" of indigent patients it would also have the effect of prohibiting all sorts of perfectly innocent actions which might have the effect of increasing the proportion of paying inpatients, such as opening a neighborhood outpatient clinic or contracting with a pre-paid health plan. This is typical of the unintended and potentially disastrous consequences which would flow from this bill.

REDUCED QUALITY OF CARE

This bill is basically designed to hold down costs by limiting increases in intensity, this is, by forcing hospitals to forego improvements in the quality of the care which they offer. Although it will be highly capricious in its impact upon individual hospitals, it is likely that many hospitals will have to either dip into their reserves of capital to cover operating expenses or cut back on the services which they offer.

Proponents of this bill argue that the one percent formula allowance for intensity is a net figure and that hospitals can exceed the one percent limit on increased expenditures for improved quality of care by eliminating waste. However, they have not been able to show that there is enough waste that could be eliminated to effect any real savings. In addition, even though a hospital might find areas of inefficiency to correct and thereby avoid the mandatory controls in one year, it is unreasonable to believe there will continue to be enough waste left to provide sufficient savings for three more consecutive years to avoid the mandatory limit in those subsequent years. What becomes obvious then is that in terms of the potential for increased service intensity, wasteful institutions will be far better off than those that are now operating close to optimum efficiency. If the inflation experience of the efficient hospitals significantly exceeds the rate of price increase allowed by the Secretary's market basket calculation,

the hospital will be forced to restrict services to prevent the total volume of operations from exceeding the revenue increase limits.

The fact is that improved hospital services have had a readily demonstrable impact on treatment results and health status of the American people. For example, in the decade between 1965 and 1975, the heart disease death rate per 100,000 population in the most vulnerable category (aged 45 to 54) fell by 21 percent. Beyond this, it is possible to isolate a number of other health status improvement indicators that directly reflect improved quality of hospital care. Between 1965 and 1975, infant deaths within seven days of birth—the period after birth most closely tied to post-natal services in hospitals—fell from 15.9 per 1,000 births to 10.0, or by 37%. Similarly, deaths from accidents fell from 25.4 per 1,000 to 17.2 per 1,000 due to improved emergency treatment. Similarly, the in-hospital death rate for heart attack victims has declined by 30% as a result of the diffusion of coronary intensive care units.

This evidence suggests that arbitrary restraints on further intensity increases could have a very deleterious effect on further improvements to health care, particularly for those who are presently medically underserved.

The historically more prosperous areas of our nation already are well endowed, even over-endowed in some cases, with sophisticated and expensive health care technology. Other areas of our country, however, have not been economically able to share in these lifesaving improvements at an equal pace and are just now beginning to expand their technological lifesaving capabilities and offer a higher intensity of health services (See Appendix). The existing regional disparities in the quality of hospital care will be frozen under the one percent intensity limit in this bill, thus effectively shutting some areas out of the market and sentencing them to a continuation of their poor mortality and morbidity statistics.

In discussing the proposed Hospital Cost Containment legislation the Congressional Budget Office has stated that by limiting growth in the intensity of services future improvements in quality might be reduced. "The proposals, moreover, limit a hospital's ability to improve quality in the face of a tight revenue constraint by requiring it to seek permission from a planning agency to reduce or eliminate one service in order to make room for a new one. . . . It would also, however, tend to freeze the system to the status quo, increasing the risk of a reduction in quality growth." [2]

FAILURE TO ADDRESS THE PROBLEM

The many flaws in this bill stem from its failure to recognize and deal with the underlying causes of the increase in hospital costs. There is a little dispute among economists that the major cause of the high rate of increase in costs is the unconstrained demand for services generated by medicare and medicaid and a tax policy which encourages the purchase of health insurance in a way that minimizes cost-consciousness in both providers and consumers. Imposing and arbitrary cap on hospital revenues will not change the incentives presently at

[2] Ibid., p. 43.

work in distortion and attempts to circumvent the controls, at great cost in terms of the quality of hospital care. Even more disturbing is the rate which the proponents of this bill envision for it. When hospital cost containment legislation was introduced over 2½ years ago it was described as a transitional program to be followed by permanent reforms in the reimbursement system. Now there is no longer any pretense that this bill would establish anything other than a permanent system of controls over hospital revenues and a crucial element of National Health insurance. If it is adopted the decision will have been made to establish pervasive control over hospitals as a first phase of National Health Insurance.

For these reasons the Subcommittee on Health and the Environment did not attempt to improve or perfect H.R. 2626 but moved to reject the bill in its entirety. The Subcommittee rightly concluded that this bill is simply the wrong response to the problem of hospital costs. Only if it is rejected can we get on with the task of changing the incentives which are responsible for the excessive increase in hospital costs.

David E. Satterfield III.
Richard Shelby.
Jim Santini.
Phil Gramm.
Tom Luken.

APPENDIX

FACILITIES, SERVICES, AND SPECIAL BEDS BY GEOGRAPHIC REGIONS[1]/

AREA[2]/	POSTOPERATIVE RECOVERY ROOM	AREA	INTENSIVE CARE UNIT (cardiac only)	AREA	INTENSIVE CARE UNIT (mixed)
(1) East North Central	84.1%	(1) Pacific	36.3%	(1) Pacific	77.9%
(2) Pacific	81.6%	(2) Middle Atlantic	36.0%	(2) Middle Atlantic	74.6%
(3) South Atlantic	81.3%	(3) South Atlantic	35.7%	(3) East North Central	72.0%
(4) Middle Atlantic	79.6%	(4) East North Central	32.2%	(4) South Atlantic	67.6%
(5) East South Central	79.6%	(5) East South Central	29.2%	(5) Mountain	65.6%
(6) West South Central	76.6%	(6) West South Central	28.0%	(6) New England	63.3%
(7) New England	73.1%	(7) New England	27.5%	(7) West South Central	61.3%
(8) Mountain	66.8%	(8) West North Central	27.5%	(8) East South Central	60.1%
(9) West North Central	66.7%	(9) Mountain	26.9%	(9) West North Central	59.8%
U.S. Average	77.6%	U.S. Average	31.7%	U.S. Average	67.7%

AREA	OPEN-HEART SURGERY FACILITIES	AREA	PHARMACY WITH REGISTERED PHARMICIST (full-time)	AREA	X-RAY THERAPY
(1) Pacific	14.0%	(1) Middle Atlantic	84.3%	(1) Middle Atlantic	34.6%
(2) East North Central	10.3%	(2) New England	81.9%	(2) East North Central	32.2%
(3) West South Central	10.0%	(3) East North Central	78.1%	(3) South Atlantic	27.0%
(4) Mountain	9.4%	(4) South Atlantic	76.2%	(4) New England	26.4%
(5) Middle Atlantic	9.1%	(5) Pacific	74.8%	(5) East South Central	26.1%
(6) South Atlantic	9.1%	(6) East South Central	67.1%	(6) Pacific	24.6%
(7) East South Central	6.4%	(7) West South Central	61.7%	(7) West South Central	22.0%
(8) New England	6.1%	(8) Mountain	58.9%	(8) West North Central	21.1%
(9) West North Central	5.7%	(9) West North Central	47.9%	(9) Mountain	18.0%
U.S. Average	9.2%	U.S. Average	70.3%	U.S. Average	26.4%

AREA	BLOOD BANK	AREA	ELECTRO-ENCEPHALOGRAPHY	AREA	RESPIRATORY THERAPY DEPARTMENT
(1) Middle Atlantic	72.4%	(1) Middle Atlantic	67.0%	(1) East South Central	80.5%
(2) East South Central	71.0%	(2) East North Central	61.7%	(2) East North Central	79.8%
(3) East North Central	68.3%	(3) Pacific	58.8%	(3) Pacific	79.5%
(4) New England	66.9%	(4) New England	54.7%	(4) Middle Atlantic	78.3%
(5) South Atlantic	65.2%	(5) South Atlantic	48.5%	(5) South Atlantic	76.7%
(6) West South Central	51.9%	(6) West South Central	43.4%	(6) West South Central	73.9%
(7) West North Central	51.8%	(7) Mountain	39.9%	(7) New England	73.3%
(8) Mountain	50.7%	(8) East South Central	38.1%	(8) Mountain	67.1%
(9) Pacific	47.0%	(9) West North Central	38.0%	(9) West North Central	61.3%
U.S. Average	60.6%	U.S. Average	51.1%	U.S. Average	74.8%

AREA	PREMATURE NURSERY	AREA	HEMODIALYSIS SERVICES (inpatient)	AREA	BURN CARE UNIT
(1) Middle Atlantic	36.4%	(1) Middle Atlantic	20.0%	(1) Pacific	3.5%
(2) Pacific	32.3%	(2) Pacific	19.1%	(2) East North Central	3.4%
(3) South Atlantic	31.7%	(3) South Atlantic	17.6%	(3) Middle Atlantic	2.6%
(4) New England	31.6%	(4) New England	14.4%	(4) Mountain	2.6%
(5) East North Central	29.6%	(5) East North Central	14.3%	(5) South Atlantic	2.0%
(6) Mountain	27.5%	(6) Mountain	12.7%	(6) West North Central	1.7%
(7) West South Central	21.6%	(7) West South Central	12.0%	(7) West South Central	1.7%
(8) East South Central	21.3%	(8) East South Central	9.1%	(8) East South Central	1.6%
(9) West North Central	19.8%	(9) West North Central	7.2%	(9) New England	1.4%
U.S. Average	28.0%	U.S. Average	14.4%	U.S. Average	2.4%

AREA	COBALT THERAPY	AREA	RADIUM THERAPY	AREA	DIAGNOSTIC RADIOISOTOPE FACILITY
(1) Middle Atlantic	19.8%	(1) Middle Atlantic	30.3%	(1) Middle Atlantic	65.3%
(2) East North Central	17.1%	(2) East North Central	26.9%	(2) East North Central	58.7%
(3) Pacific	13.6%	(3) Pacific	20.0%	(3) New England	57.0%
(4) New England	11.9%	(4) South Atlantic	17.9%	(4) Pacific	53.8%
(5) South Atlantic	11.9%	(5) New England	17.8%	(5) South Atlantic	52.5%
(6) East South Central	11.5%	(6) East South Central	16.0%	(6) East South Central	45.9%
(7) West South Central	9.7%	(7) West North Central	14.5%	(7) West South Central	42.1%
(8) West North Central	9.0%	(8) West South Central	14.1%	(8) Mountain	37.5%
(9) Mountain	7.7%	(9) Mountain	11.5%	(9) West North Central	35.7%
U.S. Average	12.9%	U.S. Average	19.6%	U.S. Average	50.8%

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AREA	THERAPEUTIC RADIOISOTOPE FACILITY		HISTOPATHOLOGY LABRATORY	AREA	ORGAN BANK
(1) Middle Atlantic	34.6%	(1) Middle Atlantic	70.6%	(1) Middle Atlantic	4.0%
(2) East North Central	27.4%	(2) East North Central	60.2%	(2) East North Central	2.8%
(3) Pacific	25.8%	(3) New England	57.2%	(3) Pacific	2.7%
(4) South Atlantic	22.6%	(4) Pacific	55.5%	(4) West South Central	2.5%
(5) New England	22.5%	(5) South Atlantic	53.7%	(5) New England	2.2%
(6) East South Central	18.7%	(6) East South Central	38.7%	(6) Mountain	2.2%
(7) West South Central	16.6%	(7) West South Central	38.5%	(7) South Atlantic	2.2%
(8) West North Central	15.9%	(8) Mountain	37.0%	(8) West North Central	2.1%
(9) Mountain	15.9%	(9) West North Central	31.3%	(9) East South Central	2.1%
U.S. Average	22.9%	U.S. Average	50.2%	U.S. Average	2.6%

1/ Source: Hospital Statistics, 1978 Edition. Data from the American Hospital Association 1977 Annual Survey.

2/ States within geographic areas:

New England	East South Central	West South Central
Connecticut	Alabama	Arknasas
Maine	Kentucky	Louisiana
Massachusetts	Mississippi	Oklahoma
New Hampshire	Tennessee	Texas
Rhode Island		
Vermont		

South Atlantic	West North Central	Mountain
Delaware	Iowa	Arizona
District of Columbia	Knasas	Colorado
Florida	Minnesota	Idaho
Georgia	Missouri	Montana
Maryland	Nebraska	Nevada
North Carolina	North Dakota	New Mexico
South Carolina	South Dakota	Utah
Virginia		Wyoming
West Virginia		

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Michigan	Pennsylvania	Hawaii
Ohio		Oregon
Wisconsin		Washington

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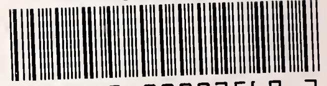
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